21 OCTOBER 2000

CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

Teamwork is key to primary care success

RPM case delayed as both sides asked to agree on evidence

What's in store for pharmacy's future

Boots' joint venture to create cable 'Wellbeing' channel

Day Lewis partnership likely next year

Update: jelly junkies and drug dependency

Online at http://www.dotpharmacy.com/

The natural way to revive your profits

- New Yariba herbal tablets contain a natural ingredient to relieve temporary tiredness
- Established clinical heritage
- Unmissable national heavyweight advertising campaign

kola nut

A natural way to revive your day

YARIBA Trademark and Product Licence held by Diomed Herbals, Hitchin, Herts, SG4 7QR, UK. Distributed by DDD Ltd, 94 Rickmansworth Road, Watford, Herts, WD18 7JJ, UK. **Directions:** Take one or two tablets three times a day. Not recommended for children under 14. **Indications:** A traditional herbal remedy used as a pick-me-up in temporary tiredness. **Contra-indications:** Not to be used in cases of sensitivity to any of the ingredients. Not to be used during pregnancy or lactation. **Precautions:** Keep out of the reach and sight of children. **Legal Category:** GSL **Packs:** Yariba (PL 17418/0012) - 50 tablets, RSP £4.95 (£4.21 exc. VAT).

CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

VOLUME 254 No 6262 141st YEAR OF PUBLICATION ISSN 0009-3033

REGULARS

COMMENT

As the content of 'Pharmacy in the Future' is debated at various events up and down the country, the implications of the government's various proposals are starting to hit home with pharmacists. Xrayser this week has picked up on the 'push' and 'pull' options for e-prescribing, and the fundamental changes they will bring to dispensary practices. Independents might prefer the 'push' option since it reduces the scope for e-pharmacies to muscle in on medicine supply, and patient registration may give the local outfit an edge. Boots, unsurprisingly, seems to prefer the 'pull' option (p4). PSNC has read between the lines and determined that contractors have nothing to fear from primary care trusts hijacking the supply chain. Improved access and out-of-hours services immediately raise the question of who pays? Local pharmacy consortia are being mooted as a possible response to one-stop health centres. As PSNC secretary Steve Axon put it recently, contractors have been threatened with relaxation of control of entry, longer hours of service, direct contracts with individual pharmacists, government-sponsored walk-in centres, and the introduction of mail/electronic dispensing. They have been offered £30m, support for medicine management, extended prescribing rights, the flexibility to develop pharmacy services, support for electronic links between surgery and pharmacy, and inclusion of the 'fourth disposition' within NHS Direct. "Like the curate's egg, most government documents are not all good or all bad. The pharmacy strategy is no exception." Pharmacists need to keep in touch with the various strands of the strategy as the proposals harden into practical applications. To help inform the process, the first of a series of articles looking at sections of the document appears this week on p16.

Editor Patrick Grice, *MRPharmS*
Assistant Editor Guy L'Amable, BA
News Editor Charles Gladwin *MRPharmS*
Business Editor Nina Keller-Henman, *Dipl Biol*
Technical Editor Steve Bremer *MRPharmS*
Contributing Editor Adrienne de Mont *MRPharmS*
Beauty Editor Sarah Thackray
Reporter Vanessa Sherwood *MRPharmS*
Art Editor Tony Lamb
Production Editor Vanessa Townsend, BA
Production Sub-Editor Lorri Pimlott
Editorial secretary Jan Powis
Editorial (tel): 01732 377487; (fax): 01732 367065; chemdrug@unitedbusinessmedia.com
Price List
Colin Simpson (*Controller*), Darren Larkin, Maria Locke
Price List (tel): 01732 377407; (fax): 01732 377559
Group Advertisement Manager
Julian de Bruxelles
Group Advertisement Executives
Christian Harris, Quentin Soldan, Sophie Wellsted
Classified Executive
Matthew Goold
Advertisement department secretary
Elaine Steele
Advertising (tel): 01732 377621; (fax): 01732 377179
Production
Karen Way
Publishing director
Fergus Wilson
Associate Publisher
John Skelton *FRPharmS*

Chemist & Druggist incorporating Retail Chemist, Pharmacy Update and Beauty Counter

Published Saturdays by United Business Media Ltd, Sovereign Way, Tonbridge, Kent TN9 1RW

C&D on the internet at chemdrug@dotpharmacy.com
Website http://www.dotpharmacy.com/

Subscriptions (Home) £137 per annum, (Overseas & Eire) $324 per annum including postage
£2.60 per copy (postage extra)
Additional Price List £78 per annum

Circulation and subscription: United Business Media Ltd, Tower House, Sovereign Park, Lathkill Street, Market Harborough, Leics LE16 9EF
Tel 01858 438809
Fax 01858 434958

Refunds on cancelled subscriptions will only be provided at the publisher's discretion, unless specifically guaranteed within the terms of subscription offer

The editorial photos used are courtesy of the suppliers whose products they feature

United Business Media

Boots says let patients choose own pharmacy

Patients should be free to choose where to take their prescriptions when electronic transfer is introduced, believes Boots the Chemists.

Pharmacy superintendent Digby Emson said last week: "At Boots we are very clear that the public's interest will be best served by a system that will allow the patient to choose when and where a prescription is dispensed. We do not believe a patient should be told where they should collect their medicine. The system we prefer would protect the patient's choice and reinstate the importance of the pharmacist/patient relationship. It would also offer advantages in terms of audit, fraud prevention and patient record transfer."

Addressing the 2000 Annual Primary Care Conference, Mr Emson said collaboration among health professionals was the key to success, backed by mutual respect.

"This means the recognition that, whether we are a GP, nurse or pharmacist, we have entered our chosen profession to try to make a difference. Each of us wants to uphold ethical standards and to achieve as much as is possible for our patients and customers."

Pharmacists did not want to practise in isolation, but as an integral part of primary care. "Indeed, I believe primary care cannot and will not exist without a strong pharmacy input," he said.

Mr Emson welcomed the Government's strategy for developing community pharmacy.

"'Pharmacy in the Future' is a positive step towards making services to patients more convenient, more comprehensive and more focused for customers," he added.

'Hail to the chief' – but not yet!

It is likely to be some time before a new chief pharmacist is appointed at the Department of Health.

The Department is in the process of short-listing applicants, with a view to holding interviews early in November, a spokeswoman said this week. There is then the possibility of second interviews and further delays while the person appointed gives notice in his or her current job.

The post was first advertised last year on Bryan Hartley's retirement, then re-advertised in September at a higher salary.

Make patients part of the team says joint report

Teamwork between patients and health professionals is vital to the success of primary healthcare, says a new multi-disciplinary report.

There is evidence that effective teamwork is most likely where each team member's role is seen as essential, roles are rewarding and there are clear goals, it says. Effective communication, optimum team size, appropriate autonomy for members of the team and adequate time and resources are also important factors.

It also adds that to empower patients to make informed decisions about their wellbeing, health and social care it will be necessary to adopt a more sophisticated approach to teamworking.

However, the report warns that although limited health resources have spurred innovative approaches, a continued shortage of resources is having a detrimental effect on development, particularly in the field of information technology. It also warns that current numbers of health professionals, particularly doctors, will be insufficient to meet future expectations.

Continuing professional development will be another key area: "CPD is essential as professions working together must have mutual confidence in their fitness to practise and their ability to keep up to date." Hence it will be important to have joint training, it says.

The report has been launched by the Forum on Teamworking in Primary Healthcare. This was convened as a result of joint working between the Royal Pharmaceutical Society, the British Medical Association, the Royal College of Nursing, the National Pharmaceutical Association and the Royal College of General Practitioners, and had support from patient groups and other health professions. Its purpose was to look at the practical aspects of teamworking in primary healthcare and to bring forward proposals which the various health professions can support.

Dame Deirdre Hine, chairperson of the Forum on Teamworking in Primary Healthcare (left), and RPSGB president Christine Glover at the launch of the teamworking report

Chairman Dame Deirdre Hine said: "Getting the right health team in place is vital to the future of healthcare in the UK. Simply bringing groups of healthcare professionals and patients together is not the answer. There need to be fundamental changes to the way both professionals and patients work together."

The Forum had found that both the professions and the public are still uncertain of their roles in the primary healthcare team, she said. "It is clear that if we are to break down the barriers, and build bridges, then the changes to ways of working are needed."

The report makes two sets of recommendations: those dealing with the establishment of teams in the primary care setting; and those made to national organisations.

For local teams, the report starts by saying the team should "recognise and include the patient, carer, or their representative, as an essential member of the primary healthcare team at individual patient-centred team level or at practice level". Team members should understand and acknowledge the skills and knowledge of team colleagues.

In addition, team leaders should be chosen for their leadership skills rather than by status, hierarchy or availability. Teams should make sure that all the relevant professions are included to serve the practice population.

'Teamworking in primary healthcare: realising shared aims in patient care' is published by the RPSGB and the BMA.

e-script pilots attract 70 enquiries

There have been over 70 expressions of interest registered with the Department of Health for the electronic transmission of prescription pilots. This is part of a process that should see routine electronic prescribing by 2004, the Department of Health has announced.

Part of the NHS 'Pharmacy in the Future' programme is for electronic transfer of prescriptions (ETP) to take place between GPs, community pharmacies and the Prescription Pricing Authority. Pilots will start in 2001 and run for at least six months. "An independent evaluation of the pilots will inform the development of a set of open standards to ensure full national integration when ETP becomes available routinely from 2004," said the DoH.

● PharMed, the non-profit organisation set up to develop an ETP system, has released its data type definition (DTD) of the anticipated prescription message. The DTD is like a template which defines the fields that will be required within electronic prescription messages and will allow GPs surgery systems to create and send messages to pharmacies.

As part of the PharMed philosophy of open industry standards, the DTD is available on request via e-mail from *info@pharmed.org.uk*.

Pharmacy input for Scots NHS plan

Scottish pharmacists had a 'very useful' meeting with Health Minister Susan Deacon last week, said Alison Strath, chairman of the Royal Pharmaceutical Society in Scotland.

Representatives of the Scottish Pharmaceutical General Council, Scottish Pharmaceutical Federation and Association of Trust Chief Pharmacists went, under the RPSiS umbrella, to discuss pharmacy's input into the NHS national plan for Scotland, due to be published on November 30.

They discussed the patient's journey through the NHS system and how pharmacists could fill any gaps, said Ms Strath. In Scotland, pharmacy will not have a separate strategy but will be integrated in the national plan, for which professional bodies are working closely with the Scottish Executive's Health Department.

RPM hearing faces slight delay

The Resale Price Maintenance case, which was due to start on Monday, was delayed a couple of days after lawyers were asked to summarise the evidence.

Last Friday, Mr Justice Lightman requested that both sides jointly produce a summary of the key areas of evidence which were not in dispute and those areas which were to be contested. As a result, the start of hearing was postponed until Wednesday afternoon, as *C&D* went to press. It was also possible that the case could have been delayed until Thursday morning if the lawyers were able to persuade the judge that additional time would allow them to agree on further areas.

The judge has acted in light of the Woolf reforms introduced last year, which are designed to save time in court. Both sides can be asked to state on which issues they agree, which may then reduce the need for evidence already supplied to be read out again in court. Mr Justice Lightman, and the two assessors sitting with him, have already spent the past fortnight going through 150 folders-worth of accumulated evidence.

It is understood that lawyers for the Office of Fair Trading have indicated that they do not wish to cross-examine the expert-witness pharmacists, who will now not be called to the witness stand. Although it may seem unfair that the court will not hear pharmacists' views, the Community Pharmacy Action Group points out that by not wanting to challenge the pharmacists' evidence the OFT appears to accept the points made.

Sheila Kelly, director of the Proprietary Association of Great Britain, said on Monday that the changes are not bad news. She also pointed out that the OFT has accepted that the case will not look at profits made by the pharmaceutical industry. Ms Kelly has received a letter from the OFT dated September 29, which says: "It is not part of the director general's [of Fair Trading] case that suppliers are making excessive profits."

This helps CPAG's case and means there will be one fewer argument to be heard in court. There had been adverse publicity early on, generated mainly by Asda, along the lines of RPM medicines contributing to a 'rip-off Britain' culture. "All the data we have collected over the past six to seven months was to refute this," said Ms Kelly. The OFT has now accepted that this is not the case, she suggested.

With fewer witnesses being called and less evidence being questioned in court, it is possible that the case will last only three weeks, compared to the originally scheduled six weeks. *C&D* will be putting regular updates of the court case on its web site at *www.dotpharmacy.com*

Mr Justice Lightman will sit with two lay assessors, rather than have the evidence heard by a jury. These are James Scott, an accountant from Arthur Anderson, and Dr Penelope Rowlitt, an economist who has been involved with the Competition Commission.

NHS Direct kiosks launched

Health minister Gisela Stuart officially launched NHS Direct information kiosks on Wednesday at an Essex pharmacy.

Seven Essex pharmacies already have the kiosks in place and a further eight will be installed soon in south-east London pharmacies. The kiosks give patients instant free access to the NHS Direct On-line web site launched last year, offering advice on various conditions and treatments, self-help group contacts and healthy living information.

The information points will be in other public places, such as supermarkets, universities and A&E departments, although pharmacies were first in the national launch of 150. Community centres in the East Midlands, and health centres in Manchester are among sites where the kiosks are already in use.

The pilot scheme aims to evaluate the most appropriate location, said NHS Direct information kiosk manager Ash Pandya.

"Pharmacies were considered suitable because of their long opening hours and their accessibility," he said. A range of pharmacies – multiples and independents – are involved in the pilot.

The system is aimed at people who do not have access to a computer or who have a fear of IT, as there is a touch screen format. There are numerous recommendations to seek advice from a pharmacist, said Mr Pandya.

The launch took place at Longthornes Pharmacy, Westcliff-on-Sea.

An NHS Direct information point in Thomas Chemist, Barking, Essex

Pharmacists seek meeting with vets over POMs

Pharmacists are seeking an urgent meeting with the British Veterinary Association to discuss how pharmacists could play a part in distributing Prescription Only veterinary medicines.

The BVA is making a strong case for the present system, in which POMs are dispensed mainly by vets. In its evidence to the Government's independent review of veterinary medicines, the BVA points out that the profession's one-stop 24 hour service has given good value for over half a century. Farmers have always had the option of obtaining a prescription from a vet and the medicines from a pharmacy, but have chosen not to do so.

Writing in *The Veterinary Record* (October 14), Andrew Cairns, chairman, and Steven Kayne, editor, Veterinary Pharmacists' Group, suggest that the BVA and Royal Pharmaceutical Society meet "to explore whether the involvement of pharmacists in the distribution of POMs would be of benefit to clients without compromising animal welfare. The reclassification of certain POMs could also be discussed".

They stress there is no intention of pharmacists usurping "the unique position that veterinarians enjoy; rather more, it is our intention to exploit the potential benefits we can offer as experts in medicines management".

The BVA's immediate past president Eifion Evans told the Veterinary Pharmacists' Group annual conference last weekend that he would try to arrange a meeting between the two bodies soon.

Mr Cairns also told a recent BVA congress in Chester about the safeguards inherent in pharmacist dispensing. He made a case for reclassifying as P, prophylactic treatments administered to entire herds or flocks of animals, where specific diagnosis was not necessary. He said that pharmacists were considering a POM(E) classification, in which a medicine could be supplied in person by a vet or pharmacist if a vet's diagnosis was not required.

IN BRIEF

Drug recall

Lundbeck Ltd is recalling all batches of its Cipramil Oral Drops (citalopram) 40mg/ml 15ml. This is due to the closure/dropper assembly not being tightened sufficiently to prevent leakage or evaporation of the contents. The Medicines Control Agency issued the class 2 alert on October 17. Further information is available from Glen Sturman at Lundbeck on 01908 649966.

Drug alert

Roche Products Ltd is recalling four batches of Cara-Nitro Pump Spray (glyceryl trinitrate) 0.4mg/dose (200 doses) due to reports of sprays failing to deliver a dose upon first use. Affected batches are: GBC090B with expiry March 2002; GBD106A exp April 2002; GBE040A and GBE086A both expiry May 2002. The class 2 recall was issued by the MCA on October 11. Information is available from Roche Customer Services on Freephone 0800 732 5711.

Pharmaid Week

The annual collection of recent editions of the *BNF*, for Book Aid International, will take place in the week beginning November 13. AAH delivery vans will collect the books.

UniChem's third pharmacist development weekend took place in Gloucester last weekend. The sessions dealt with a variety of issues including a user-friendly guide to category-management and customer service training. The clinical workshops covered topics such as smoking cessation, Cox2 inhibitors and gastro-oesophageal reflux. Participants of the College of Pharmacy Practice accredited course were awarded 8 hours of COPD. The next training weekend will be held on November 3-5 in Harrogate

Doctors say no to diagnosis by pharmacists

The World Medical Association is to issue a public statement saying it is improper for pharmacists to diagnose and treat illness.

The decision was made at a recent meeting in Edinburgh, at which the Spanish Medical Association presented a paper referring to a local dispute over the roles of pharmacists and doctors. The meeting decided to send a letter of support, issue a press release and set up a working group of medical associations to look at relationships between the two professions.

Nigel Duncan, WMA's press officer in the UK, said the Association and the International Pharmaceutical Federation had been considering the matter for some time. The Edinburgh meeting did not approve the Spanish paper as such but gave its support to the principle that diagnosis should remain in the hands of doctors. He added that the British Medical Association still held that view despite acknowledging the pharmacist's role in advising on non-prescription medicines.

The Edinburgh meeting also revised the Declaration of Helsinki, first drawn up in 1964 in response to the atrocities of the second world war. The declaration has become the most widely accepted guidance worldwide on medical research involving human participants.

The WMA was particularly concerned about protecting people in poorer countries from being used as research subjects for the benefit of others. The new declaration specifies that every patient entered into a study should have access to the best treatment when the study is over. Testing of any new treatment must be done against the current best method and not against placebo, the reasoning being that people in developing countries would at least get the best existing treatment.

The revised declaration also emphasises more clearly that all participants must give their informed consent freely, preferably in writing, and that those who cannot should be included in research only under exceptional conditions.

Dr Anders Milton, WMA chairman, said: "Research should not be carried out in countries in development just because it is cheaper and the laws are more lax. The same ethical rules should apply wherever research is being conducted."

The WMA is an independent confederation of medical associations representing over 8 million doctors in about 70 countries.

Future for pharmacy is holistic

The first stage of a pharmacy that aims to offer a comprehensive walk-in health and wellbeing service has opened in Birkenhead, Merseyside.

Smoking cessation clubs, steam rooms for help in asthma clinics, a 'conference' room for meetings, healthy-eating support, and complementary therapies with a 'holistic pharmacy' will be offered alongside traditional pharmaceutical and medical services. An on-site laboratory will be able to provide both a local and national diagnostic testing service.

Chanin's Holistic Healing Centre is a converted warehouse, of 5,000ft². The first stage of the development was opened last weekend, with the whole fitting-out process expected to be finished by January. The pharmacy has an NHS contract and is near a new GP surgery. The Centre will also offer private medical, dental and optical services, and has a range of consultation and treatment rooms for complementary therapy.

Originally, the Chanins were to apply for their pharmacy to become an NHS walk-in centre, but withdrew due to application costs. However, they have decided to continue with the plans as part of an ongoing process for their small chain of pharmacies, sensing that the future of pharmacy will not lie in retailing.

UniChem's Pharmacy Alliance has shown a great deal of interest in the Centre, and is supporting the venture. Normally, Pharmacy Alliance would expect members to take on one new area of clinical interest each year. Phase 1 of this latest Chanins' pharmacy will offer six core programmes by the end of this year with schemes such as osteoporosis management, allergy testing and diabetes clinics.

The Health Action Zone is likely to use the Centre's smoking cessation programmes as the HAZ's own facilities are over subscribed. And the local healthy living centre has expressed interest in using the facilities.

Lynda Chanin told *C&D* that she and her husband Chris, both pharmacists, decided that there was no future in the normal pharmacy route. The Holistic Healing Centre is not seen as a "normal retail outlet, but an outlet for services" and has been spurred on by pharmacy developments such as diagnostics and medicines management. The NHS Plan has given the Chanins even greater impetus.

The Chanins have worked with independent business consultant Brian Jones of Bristol over the past four years developing their other three pharmacies. Mr Jones believes that extending the range of services will encourage greater use by the public and keep the centre viable despite its limited retailing offer. It is hoped GPs will refer patients for both NHS and private treatment.

Mrs Chanin says they are keen to share the experience and want to let pharmacist colleagues and other health professionals use the facilities. "We want allies - this is a model for the future of pharmacy," she said.

Pictured at the opening last Sunday of Chanin's Holistic Healing Centre, which attracted 170 visitors, are (from left): business consultant Brian Jones, owners Lynda and Chris Chanin, and UniChem pharmacy development manager for Merseyside and North Wales, Dave O'Hagan

Pharma-bridge the gap

Pharmacists and pharmacy associations in the UK are being encouraged to make links with their counterparts in developing countries.

The Pharmabridge project is promoting the creation of institutional and personal links. It hopes that developed countries will support pharmacy overseas by the provision of books, periodical subscriptions, access to training and faculty and exchange opportunities.

More offers of help are required to meet the needs of pharmacy, especially in Africa and South-East Asia. Information about the scheme is available from: Agathe Wehrli, 35, rue de la Prulay, 1217 Meyrin, Switzerland. Tel: +41 22 782 9166 or e-mail: *wehrlia@bluewin.ch*

Pharmabridge is supported by the International Pharmaceutical Federation and the Commonwealth Pharmaceutical Association.

A dispenser from Moss Pharmacy, Melton Mowbray, has just started the pharmacy degree course at De Montfort University, Leicester. Unusually, Anna Hodgkinson was awarded her place after successfully completing the Pharmacy Services NVQ level three, not A-levels. The NVQ course is run by the NPA, and John Hind, NPA board director, said: " I am extremely impressed by the high degree of enthusiasm and dedication that Anna has shown. She has clearly worked hard and her success is well deserved." Anna is shown here receiving an award in recognition of her achievements from John Hind (right) and Steve Eggleston (centre, Moss Pharmacy area manager)

INDUSTRY VIEWPOINT

With one very loud voice

It was interesting to learn that Steve Dunn, managing director of AAH Pharmaceuticals, wrote to the main pharmaceutical organisations encouraging them to intensify their lobbying activities to the Government. The spur for this was an announcement by the Department of Trade & Industry that Post Offices are likely to receive subsidies to help with their transition to new roles within local communities. He went on to recommend that "we should consider a cross-body group to lobby and communicate strategic messages".

Conventionally, this lobbying role lies with the Royal Pharmaceutical Society, the National Pharmaceutical Association, the Pharmaceutical Services Negotiating Committee and the Company Chemists Association. Mr Dunn clearly believes there is a different opportunity and he is almost certainly right.

"We should consider a cross-body group to lobby"

There are two organisations that could act as role models. The ABPI represent the major manufacturers in the ethical industry and the PAGB represents OTC manufacturers. While much of their time is focused on regulatory issues, they have also evolved into highly effective lobbying machines. There is, inevitably, strong commercial involvement, and self-interest is a major driving force.

Just imagine what might happen if it were possible to bring together the CEOs of Boots, Gehe, Alliance UniChem, Numark and Phoenix to plan a major communication programme with the Government. Through their companies they could directly or indirectly represent the commercial interests of every pharmacist and pharmacy organisation in the UK.

This would be real commercial pressure on the Government. It should also be possible to raise sufficient annual revenue to fund a team of well-organised lobbyists representing the commercial interests of the pharmaceutical and pharmacy organisations in the UK. The difference between this group and the other pharmacy organisations is size – just five major business leaders, speed (with decisions implemented immediately through their commercial organisations), and significant financial strength – a voice that would be listened to … in fact, one very loud voice!

Contributed by a senior industry manager

Xrayser

Topical Reflections

E-prescribing – getting down to the nitty-gritty

The debate over the preferred method for the electronic transmission of prescriptions will rage for months if not years. David Watkinson, director of customer technology at AAH Pharmaceuticals, set the ball rolling at the National Association of Co-operative Executive Pharmacists with an excellent comparison of the 'push' or 'pull' models (*C&D* October 14, p26).

The 'push' model makes a pharmacist's life much easier, while the 'pull' model is more flexible for the patient However, whichever one is adopted – or even a third alternative – the decision must not be taken lightly.

Electronic prescribing, of all the ideas in the 'Pharmacy in the Future' strategy, is the one that will have the most profound effect on current practice.

The Government has requested bids for pilots tied to a tight time scale, but so far I have not seen the criteria against which the success of any system will be judged. It is the criteria that need the maximum debate and not the technology to achieve them.

Any system that is adopted must ensure total freedom of choice for the patient, it must maintain a fair and open playing field for all participants and it must improve quality of care.

Strict patient registration as required by 'push' would restrict a patient's freedom of choice and limit competition. 'Push' would also encourage direction and commercial manipulation.

Conversely 'pull' means pharmacists would be unable to anticipate demand, so perpetuating those long waits in busy pharmacies and thus negating many of the potential improvements in patient care by inefficiency of supply.

Both systems would also require some form of patient identification, so once again raising the spectre of 'big brother' identification cards.

The Government seems to be rushing into seeking bids for electronic prescribing before establishing the ground rules or thoroughly understanding the consequences.

The debate may have occurred behind closed doors, but for the protection of the patient and for good pharmaceutical practice this should occur in public and the results be published. Then the Government can go full steam ahead with its pilots and independent evaluation.

POM to P – has the MCA moved the goal posts?

It seems the move towards deregulating Levonelle-2 from 'POM to P' could soon be a reality, so the publication by the Royal Pharmaceutical Society of the standards for its supply by pharmacists is to be welcomed.

It is ironic that the reason Levonelle-2 has so quickly transferred to Pharmacy status is that it has been proven to be very safe. However, I can see no prospect of the Medicines Control Agency suggesting that safety makes Levonelle-2 an ideal candidate for 'GSL' and, therefore, available alongside the ibuprofen, NRT chewing gum and 'maximum strength' cold preparations on garage forecourts throughout the country!

So why this sudden change of heart by the MCA and does this mean that at long last the Agency has seen sense and is now considering the 'added value' of pharmacist supervision of 'P' sales to be a factor when determining regulatory changes?

I wish! That is my immediate reaction, because this is a classic case of moving the goal posts when it suits. Of course Levonelle-2 must only be sold through pharmacies and I do not think there can be many who would dispute that statement, but the MCA has always maintained that its terms of reference preclude all considerations other than safety.

If Levonelle-2 has been made an exception, what will happen in the future as the Government intends to continue to press for deregulation of other POM medicines? I would like to see as the next candidate chloramphenicol eye preparations, but again strict standards for supply would have to be applied.

I welcome this apparent change of instruction to the MCA and equally look forward to the deregulation of more drugs under similar circumstances, but if switches in the future need control, then the same standards should be retrospectively applied to past failures.

I refuse and refer more requests for ibuprofen than any other medicine in the pharmacy. Safe it may be for those who can tolerate it, but I wonder how many asthma attacks and gastric bleeds could be attributed to its uncontrolled availability as a GSL medicine.

Statutory Committee

Restoration

A pharmacist who stole money from her employers because she wanted "a black mark" against her name was restored to the Register last week.

At the time of the theft, Anne Longworth had been addicted to temazepam, the Royal Pharmaceutical Society's Statutory Committee heard, and wanted to make it difficult for herself to return to the profession.

Mrs Longworth, of Sandbach, Cheshire, had, said Geoffrey Hudson for the Society, applied in January 1992 for her name to be removed from the Register, although due to a technicality this did not happen until April that year.

Mr Hudson said it was the Society's case that Mrs Longworth's convictions offended the Society's Code of Ethics.

Mrs Longworth had begun taking sleeping tablets due to personal problems, but then found she was dependent on temazepam.

After her conviction for theft Mrs Longworth began to sort out her drug problem. On Millennium Eve, Mrs Longworth told the tribunal, she decided she really "wanted to go back to pharmacy again". For the past six months she has been working as a volunteer in a pharmacy in Stoke on Trent.

Joe Mee, co-ordinator of the Pharmacists Health Support Scheme, said of Mrs Longworth: "I do feel very confident in this particular case."

The Committee ordered Mrs Longworth's name to be restored to the Register, subject to her undertaking to go on courses and not to practise as the pharmacist in personal control for six months.

Ruling on syringe mix-up case

A pharmacist gave a patient syringes that had already been used, the Statutory Committee heard last week.

He had never dispensed the medicine before and did not open the box to check it was correct.

The Royal Pharmaceutical Society heard that the patient, referred to only as 'Patient BB' had to undergo treatment to protect her from possible infections, including hepatitis. During the period she was also not given adequate protection in relation to the anti-coagulant medicine. However, she is described now as being "well".

Antony Vincent Johnson, Sheila Davis, Sheila Margaret Daxter, and Gylla Ltd, faced a number of allegations of misconduct.

Geoffrey Hudson, for the Society, said Gylla Ltd owns two pharmacies in Gillingham, Dorset - the Barn Surgery Pharmacy and St Mary's Pharmacy. The shareholders in the company are Mr Johnson, Mrs Daxter and her husband. Mrs Daxter was in charge of St Mary's Pharmacy, although she did not work there full time. Mr Johnson was usually in charge at the Barn Surgery Pharmacy. Both are directors of the company, Mr Hudson said.

The Committee heard that a patient of the Barn Surgery returned syringes to the pharmacy some time after December 1998. That pharmacy accepted them, but somehow they got to St Mary's Pharmacy, said Mr Hudson.

On February 5, 1999, the Committee heard, patient BB handed in a prescription at the Barn Surgery Pharmacy for pre-filled syringes of the anti-coagulant, dalteparin. As there were none in stock, Mr Johnson, who was in charge at the Barn Surgery Pharmacy that day, telephoned Mrs Davis and asked her to send some over.

Mrs Davis, in charge of the St Mary's Pharmacy, placed the syringes in a skillet, put a St Mary's label with details of the medication on it and sent the box to the Barn Surgery Pharmacy. Mr Johnson looked at the sticker on the skillet, but not inside. The box was relabelled and left for collection. Patient BB later picked up the medication.

A nurse at the Barn Surgery Medical Practice injected patient BB on two occasions. The third time another nurse administered the medication and noticed the syringes had been used and were almost empty.

The Committee also heard that on July 7, 1999, Anthony Jackson, a Society inspector found three items with dispensing labels from other pharmacies in a drawer at the St Mary's Pharmacy.

Gylla Ltd admitted the absence at St Mary's Pharmacy, before July 7, 1999, of an adequate system to ensure medicines returned by patients were not placed in dispensing drawers. It was also accepted by the company that between February 26 and July 7, 1999, there was a failure to make effective checks at the pharmacy to ensure no returned medicines from patients were kept in the drawers there.

The company denied it was guilty of misconduct in repackaging the returned medicine at the St Mary's Pharmacy on February 5, 1999, and dispensing it at the Barn Surgery later. This was on the basis that Mrs Daxter had delegated her responsibilities for supplying medicine to a registered pharmacist.

Mr Johnson, the Committee heard, admitted misconduct in that he had failed to check the package sent from St Mary's Pharmacy and had dispensed/supplied a returned medicine to BB.

Mrs Davis admitted misconduct in repackaging the syringes, to the extent she had checked them but did not notice they had small amounts of medicine in them, Mr Hudson said.

Mr Johnson told the Committee: "I'd never dispensed it before," as another medication was more commonly used as an anti-coagulant, namely warfarin.

At a meeting on February 26 last year, he assured patient BB the problem would not happen again. Mr Johnson said they had been careful at the Barn Surgery Pharmacy since then.

Mrs Davis admitted she had never dispensed the medicine previously, but said that a written protocol had now been introduced for dealing with patient-returned medicine.

Because improvements in the system had been put in place, the three pharmacists were only reprimanded.

Chairman of the Committee Lord Fraser, Carmyllie, QC, added, though, that there "remains some room for improvement in the system of the two pharmacies".

He said the Committee felt there was no advantage in imposing a separate penalty on the company, Gylla Ltd.

Society clears barrister – but issues a reprimand

A reprimand has been issued to a pharmacist, who is also a barrister, over his help for another pharmacist in Hampshire.

Statutory Committee chairman, Lord Fraser of Carmyllie, QC, said Andrew Baker of Hook, Hants, was guilty of such professional misconduct in early 1998 by failing in his professional responsibilities. He should have corrected the Society's understanding of his role in the operation of a pharmacy.

However, Mr Baker had been well-intentioned and badly let down by the pharmacist he had helped out, added Lord Fraser.

Buckskin Pharmacy, in Buckskin, Basingstoke, Hants, had been run by Geoffrey Whitechureh until November 18, 1997, when his name was removed from the Register (*C&D* November 22, 1997, p4) following an appeal against the Society's decision. Mr Baker, who qualified as a pharmacist in 1987 and as a barrister in 1990, had acted for Mr Whitechurch on this appeal.

The Committee heard that the next day, Mr Whitechurch transferred the ownership of the pharmacy to Eastrop Analytical Services Ltd. The same day, November 19, 1997, Mr Baker allegedly signed a form notifying the Society that as from that date he would be superintendent pharmacist. He also signed a copy of the same form on November 21.

In January, 1998, Mr Baker sent written confirmation to the Society that he had received its guidance notes and he accepted his responsibilities as the pharmacist.

On Saturday January 23, 1999, Mr Bradley told the Committee, Stephen Lutener, head of pharmacy law at the Society and Timothy Snewin, a senior inspector, visited the pharmacy.

Mr Lutener bought Day Nurse capsules from an assistant and saw a customer buying Imodium. Both were Pharmacy medicines and as only the assistant and Mr Whitechurch were present they were sold unsupervised.

Mr Bradley said the two men then interviewed Mr Whitechurch and discovered in addition that no pharmacist was in the shop when sales took place on the previous four days.

After looking at records they found 266 prescriptions had been dealt with on those days, including Controlled Drugs.

Mr Whitechurch is then alleged to have told them: "There was really very little involvement at all," from Mr Baker.

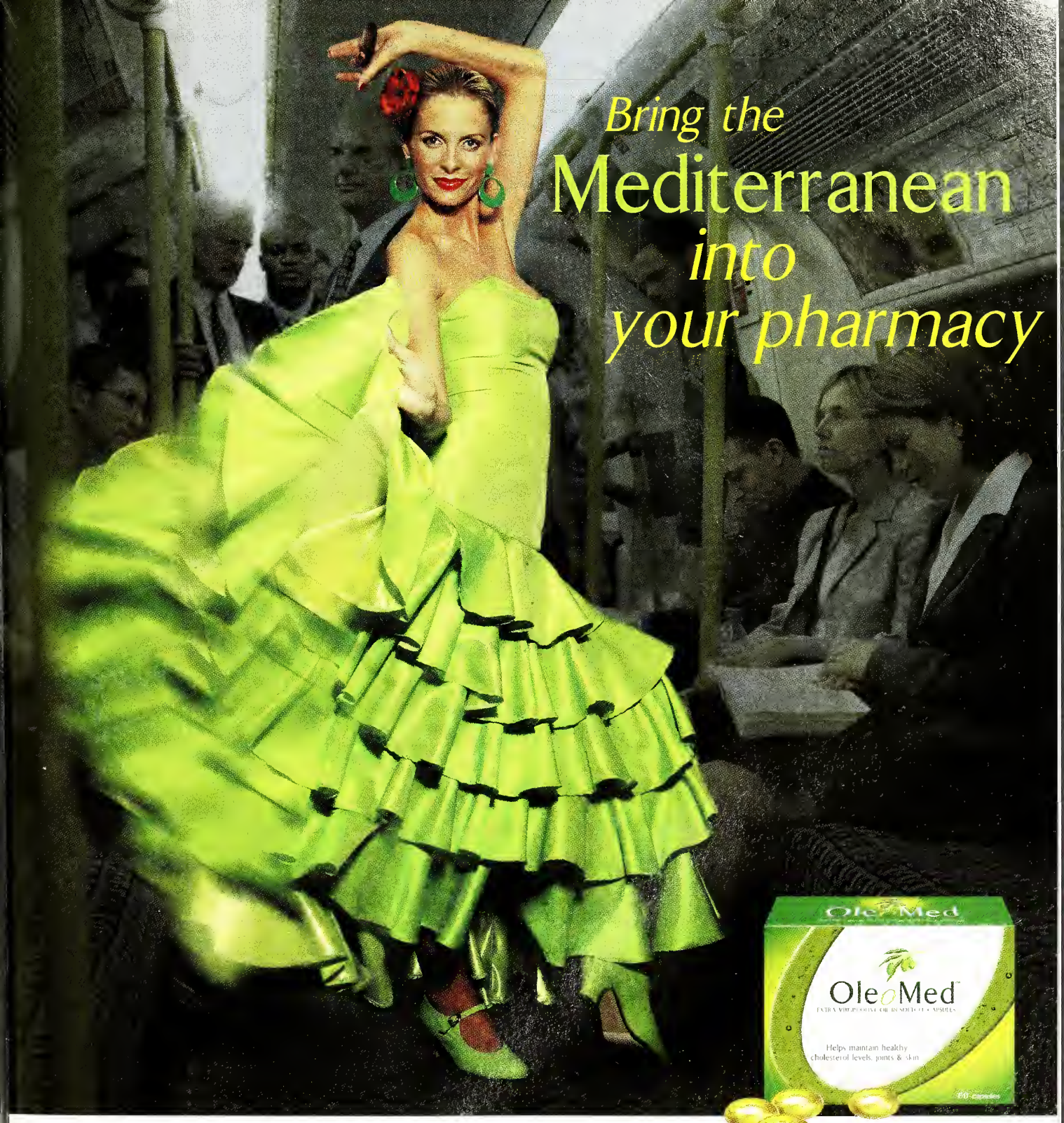
When Mr Lutener and Mr Snewin spoke to Mr Baker later that day, he told them he had resigned from the pharmacy in spring or summer 1998, said Mr Bradley.

It was alleged that Mr Baker had said in a letter that there was no obligation on a pharmacist to notify the Society he had resigned. Mr Baker also said he had resigned around 1997.

Mr Baker said that after the November 1997 appeal hearing regarding Mr Whitechurch, he thought that a superintendent pharmacist had to be appointed immediately. He offered verbally to hold the position for Mr Whitechurch, but only until Christmas 1997.

Mr Baker told the Committee he advised Mr Whitechurch the business needed to be sold and they "fell out" over this. Mr Baker also said he sent a Christmas card in 1997 to Mr Whitechurch, which enclosed his resignation. He signed the confirmation accepting responsibilities as a pharmacist because he thought it applied retrospectively. Mr Baker said with hindsight he should perhaps have informed the Society he had resigned, but there was no legal requirement on him to do so.

He was cleared of the allegation that he had failed to perform his duties properly resulting in unsupervised sales on various dates in January 1999 because there was insufficient evidence he was the superintendent pharmacist on those dates.



Olive oil can help maintain a healthy cholesterol level, keep joints supple, and care for skin. It's rich in monounsaturated fat and in vitamin E.

New OleoMed capsules contain olive oil at its very purest - extra virgin olive oil.

Two capsules daily can bring benefits to your customers, and healthy profit to you.

OleoMed is available with extra virgin olive oil alone, and with additional food supplements*.

Whether it's extra virgin olive oil, or extra virgin olive oil with extra supplements, OleoMed always offers extra profits.

OleoMed™

EXTRA VIRGIN OLIVE OIL IN SOFTGEL CAPSULES

*The OleoMed range includes:

Extra virgin olive oil • Extra virgin olive oil with Evening Primrose Oil • Extra virgin olive oil with Calcium • Extra virgin olive oil with Omega 3, Omega 6 & Vitamin E • Extra virgin olive oil with Garlic • Extra virgin olive oil with Ginkgo Biloba

For further information contact:

Pharmed Ltd, Bourne Road, Bexley, Kent, DA5 1NX. Tel: 01322 550550

Medical matters

IN BRIEF

Two generics from APS/Berk

APS/Berk is launching its own famotidine and trazodone products. The basic NHS price for packs of 28 famotidine tablets is £13.37 for the 20mg and £25.40 for the 40mg. And for the trazodone, 84x50mg capsules is £17.31, 56x100mg capsules is £20.38, and 28x150mg tablets is £11.62.

APS/Berk.
Tel: 0113 238 0099.

SPC for NiQuitin CQ reviewed

NiQuitin CQ is now contraindicated in patients with recent myocardial infarction, unstable or worsening angina pectoris, Prinzmetal's angina, severe cardiac arrhythmias, or recent cerebrovascular accident. Adolescents aged 12-17 are advised to see a doctor before using the patches. Dosages of tacrine and clomipramine may require reduction.

SmithKline Beecham Consumer Healthcare UK.
Tel: 020 8560 5151.

Pariet licensed for H pylori therapy

Pariet has been approved, in combination with appropriate antibacterial therapeutic regimens, for the eradication of *H pylori* in patients with peptic ulcer disease. Recommended dosage is Pariet 20mg twice daily plus clarithromycin 500mg twice daily plus amoxicillin 1g twice daily, for seven days.

Eisai Ltd.
Tel: 020 8600 1400.

Fresubin range addition

Fresenius Kabi is launching Fresubin 1000 Complete. It is a nutritionally complete tube feed for patients with low energy requirements and is ACBS approved. The basic NHS price for a 1,000ml Easybag is £8.20.

Fresenius Kabi Ltd.
Tel: 01925 898000.

Eucardic SPC reviewed

The regulatory status for Eucardic has reverted to the situation before July. That is, Eucardic should not be initiated in patients with severe chronic heart failure. Initiation of therapy in patients with chronic heart failure and its titration should only be under the supervision of a hospital physician.

Roche Products Ltd.
Tel: 01707 366000.

Family links for cancer and pill

First generation oral contraceptives have been linked to an increased risk of breast cancer among women who have a first-degree relative with the disease.

This was the conclusion of a US historical cohort study, published in the *Journal of the American Medical Association*, of 426 families of women diagnosed with breast cancer.

Participants were 394 sisters and daughters of the women, 3,002 granddaughters and nieces, and 2,754 women who married into the families.

After accounting for age and birth cohort, having used an oral contraceptive was associated with a three-fold increase in breast cancer risk for sisters and daughters of the affected women. But there was no significantly increased risk for granddaughters, nieces and those who had married into the family. Results were essentially unchanged after adjustment for several other factors, such as age at first delivery.

A higher risk among women with a first-degree familial history of breast cancer was most evident for contraceptive use prior to 1975, when preparations were more likely to contain higher doses of oestrogen and progestogens. The study only identified two women with breast cancer who had taken contraceptives after 1975 and who had first-degree relatives who also had the disease. This sample was too small to be effectively statistically analysed.

Smaller packs cut paracetamol overdose size

Paracetamol pack-size reductions have cut the number of tablets taken in individual overdoses, but have not reduced the incidence of severe liver failure.

A study in the *British Medical Journal* compared self-poisoning cases in two periods of six months before and after the pack size legislation was introduced. The study looked at 590 patients presenting with acute self-poisoning to five Belfast hospitals between January and June in 1998 and 594 patients presenting during the same period in 1999.

Between the 1998 and 1999 study periods, the estimated quantity of paracetamol ingested was reduced from 10g to 8g. In 1998, 398 patients were admitted to hospital and 183 given antidote, compared to 374 admitted and 149 given antidote in 1999.

In 1998, two patients were referred to a tertiary referral centre, but three were referred in 1999. In 1998, both patients recovered fully without a liver transplant. In 1999, only one recovered completely, one received a liver transplant, and one died.

Half of HAs not funding Alzheimer's drugs

Over half of health authorities and boards do not fund anticholinesterase inhibitors for treating Alzheimer's disease, according to a survey.

In most of the areas without formal funding, individual GPs or hospital trusts are supplying some patients with the drugs. But in a sixth of the areas surveyed, there is no mechanism to obtain these drugs on the NHS.

Of the 45 HAs that did fund the drugs, 60 per cent have laid down protocols for their use, and 56 per cent restricted their use to consultants only. Other restrictions included capped budgets, set by 27 per cent of authorities, and restricted patient numbers, which were imposed by 11 per cent.

The survey, carried out by researchers from the Maudsley Hospital and Tower Hamlets Primary Care Group, looked at prescribing and funding of donepezil and rivastigmine. Recently launched galantamine was not available at the time of the survey. Questionnaires on the use and funding of the drugs were sent to the prescribing advisers of all 135 health authorities or boards in Britain. Almost three-quarters were returned.

Of the authorities not funding the drugs, 14 per cent said they were waiting for guidelines from the National Institute for Clinical Excellence, which are expected to be issued at the end of November. The researchers cited this as evidence of 'NICE blight' - where authorities are refusing to use treatments while NICE is considering them.

Study tests effectiveness of asthma treatments for children

Both budesonide and nedocromil have been shown to be no more effective at improving lung function than placebo in children with mild to moderate asthma. But inhaled budesonide improves airway responsiveness and provides better asthma control than placebo or nedocromil.

The study in *The New England Journal of Medicine* also showed that the side effects of budesonide are limited to a small and transient reduction in growth velocity. Nedocromil had no more effect on growth rate than placebo.

Over 1,000 children aged 5-12 years with mild to moderate asthma were randomly assigned to receive either budesonide, nedocromil, or placebo. Participants were treated for four to six years. All children used salbutamol for asthma symptoms.

There was no difference between the treatments and the placebo in the primary outcome measure - the degree of change in the forced expiratory volume in one second (FEV1) after bronchodilator administration. Those given budesonide needed fewer urgent visits to a caregiver, less salbutamol for symptoms, and fewer courses of prednisone. Nedocromil significantly reduced urgent care visits and courses of prednisone.

The mean increase in height in the budesonide group was 1.1cm less than in the placebo group, which was most evident in the first year. All groups had a similar growth velocity by the end of the treatment period.

New Calrub.
On the shelf one minute.
Vapourised the next.

New Calrub Vapour Rub is specially formulated for your younger customers. Warming, soothing and comforting, it is non-sticky and quickly absorbed. Gently massaged onto a child's chest or back, it will also release a soothing vapour for clear and easy breathing.

With a new advertising campaign in the parenting press this winter, customers will be asking for Calrub by name. So stock up today – you'll be amazed how quickly it vanishes into thin air.

Counterpoints

New contraceptive for modern women

Sinclair Pharmaceuticals' new vaginal contraceptive sponge, Protectaid, is made from soft, pliable foam, impregnated with F-5 gel.

This spermicidal gel contains nonoxynol-9, sodium cholate and benzalkonium chloride. It is effective at low concentrations, reducing side effects such as itching or irritation.

Used correctly, Protectaid offers about 90 per cent protection against pregnancy. It should be inserted at least 15 minutes before sexual intercourse and is effective for up to six hours.

Retail price is £9.95 for a pack of four.

Sinclair Pharmaceuticals Ltd.
Tel: 01483 426644.

Just what you're spraying for?

Essential Health Products is launching a spray version of its 'Helps Stop Snoring' remedy this month.

The spray will be more convenient to use than the gargle, which has to be diluted in water first.

Retail price of the spray is £11.99 for 19ml (seven weeks supply). It will be sold exclusively through Boots for the first six months.

Ceuta Healthcare Ltd.
Tel: 01202 780558.

Pick ice for pain relief

The Mentholatum Company is making a new product available for sufferers from migraines and severe headaches next month.

Migraine Ice patches include a special technology which uses a water-based gel to give instant pain relief.

The patches are based on 'cooling therapy' where the application of cold compresses to an area of pain may help reduce the length and severity of the discomfort.

Retail price is £3.99 for a pack containing two large patches which can be cut to size and placed on the forehead, temples or back of the neck.

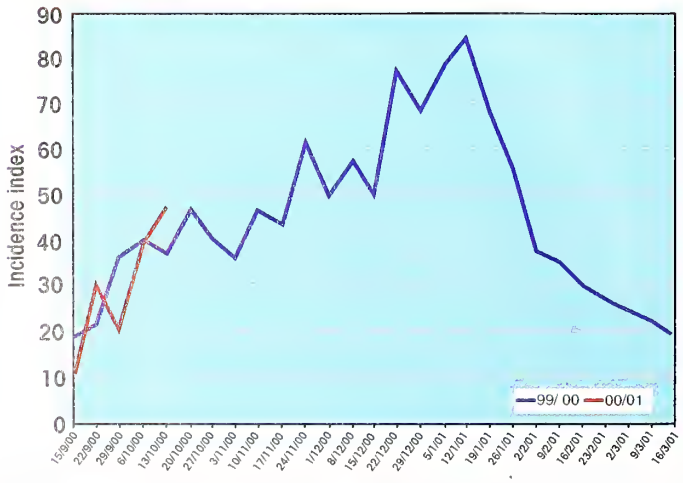
Boehringer Trade Services.
Tel: 01344 741493.

Cough, cold & flu FORECAST

Information updated weekly by SDI

SPONSORED BY Benylin

United Kingdom	Status level	Number of weeks on status	Season 2000/2001 projected population affected by respiratory illness	2000/2001 vs. 1999/2000 cumulative season-to-date % difference
BIRMINGHAM	Advisory	1 week	172,017	31.35%
BRISTOL	Advisory	1 week	44,395	25.68%
GLASGOW	Normal	5 weeks	36,568	-16.68%
LEEDS	Advisory	2 weeks	157,767	43.42%
LONDON	Advisory	1 week	637,361	-13.83%
MANCHESTER	Advisory	1 week	206,180	21.80%
NEWCASTLE	Advisory	1 week	17,197	3.57%
NORWICH	Advisory	2 weeks	13,935	28.37%



Once again, *C&D* is featuring the Cold & Flu Forecast, sponsored by Benylin.

The information carried each week will help pharmacists predict peaks in seasonal illness, get product on-shelf at the right time, reduce out-of-stocks and help with inventory management.

In eight UK cities, volunteer panels, including GPs, pharmacists and staff from hospitals and nursing homes, have been set up and, at the beginning of each week throughout the season, they will report to the Forecasting Centre on the current incidence of flu/cold/respiratory illness or appropriate absences.

A complex computer programme then uses weighting factors and algorithms to determine the incidence in each city for that week. By Friday, the Centre is ready to forecast for the following week.

There are five important FAN status levels of respiratory illness:

- Normal: Little or no increase in respiratory illness
- Advisory: A measured increase in respiratory illness
- Pre-Alert: Levels of illness will go to Alert in 3-5 weeks
- Alert Status: A severe increase in illness (peak); 77 per cent of households will be affected. Lasts 8-10 weeks
- Advisory Status (down): Measured decrease in illness.

The system also highlights which symptoms are predominant in any 'Alert' period, eg cough, sore throat.

Sweet solution to sore throats

Health Imports is introducing Goodypops to soothe children's sore throats.

The lollipops contain 50mg of echinacea and 20mg of vitamin C, to help boost the immune system, and 10mg of pectin to coat the throat.

'BananaMan and Buzzbee' lollipops are banana and honey flavour and 'BerryBuddies' are field-berry flavour.

Retail price is £1.95 for a pack of eight lollies.

Health Imports Ltd.
Tel: 01274 488511.

Advantage has all the answers

The questions pharmacists most regularly ask about Norton Advantage are answered here by Paul Burden, Product Manager for Norton Advantage

Why should I join Norton Advantage? Are there real benefits for us as a retail pharmacy?

Our membership has continued to grow as more and more pharmacies appreciate the service levels that Norton Advantage provides. There are now more than 3,800 pharmacies benefiting from a streamlined order facility through a single account as well as twice daily deliveries and competitive pricing across the Norton Healthcare range.

All this means members can avoid bulk buying and make the associated cash-flow and storage cost savings.

The commercial environment today is fiercely competitive so it is vitally important loyalty schemes recognise both the professional and business requirements in pharmacy. How does Norton do this?

One way is through co-operation with our wholesale partners who are vital to making the Norton Advantage Scheme work. Our Business Partners are at the coalface, dealing with our pharmacy customers who are the first on the phone if the levels of service are not what they have come to expect.

That sounds great, but how have you managed to ensure that the Advantage scheme, which is now four years old, is as relevant today as it was when it was launched? After all, there have been a lot of changes in the retail pharmacy market.

We know that everyone has been affected by market changes, especially over the past 12 months with EU directives driving the shift to patient packs, for example.

We have carried out detailed research projects to ensure we understand what our customers want and to find out why some pharmacies do not buy through the Advantage scheme. We are making changes that will benefit everyone. The results of this research are being introduced now and more improvements are planned.

Advantage offers:

- Simplicity in pricing structure
- Visibility via a market price list
- Clarity with an interactive web site

Can you explain in more detail what the improvements are and how exactly pharmacy members will benefit?

Advantage's key offer has not changed but we are now offering customers simplicity, visibility and clarity. Simplicity through a simplified pricing structure; visibility through a market price list sent direct to members; and clarity through our fully interactive web site *www.nortonadvantage.com*.

I used to find my invoice pricing was inflated because you gave me credits and I had to trust Norton. Is this going to continue?

Last year we changed to weekly credits so that pharmacies can spend the money in their account before they actually have to settle their invoices. This has been extremely popular with existing Advantage members.

From the beginning of October, we will also reduce the variance between the invoice prices and market prices which means up front payments will be reduced and fewer credits will build up in members' accounts.

In the past I could not see exactly what I was paying. Will this change with the improvements Norton is introducing?

Historically our members had to call our telesales team to obtain the latest prices. From the beginning of October, we will be giving our members access to real time price lists over the internet (secure connection) along with mailing directly to their doors. This will happen at the start of each month.

I have found reaching the bonus target levels difficult. Can something be done about that?

We have looked into how the bonus grid system has worked for our members. We have taken feedback from our customers into account, and have changed the bonus structure to suit their needs.

As a result targets are easier to achieve and it is easier for pharmacies to progress up the bonus levels.

The new system can be accessed on *www.nortonadvantage.com* which shows Advantage members in simple terms exactly what they have to do to reach the next level while allowing them to track their progress.

I have been impressed by the intranet browser that the rep has shown me detailing my Advantage account, but I am often too busy to study it when they are in the shop. I would like to be able to view the information on my own computer in my own time. Will this be possible?

Yes! From the begining of October, members will be able to access *www.nortonadvantage.com* and see their account details. There will be a general area explaining how the Advantage scheme works and a password-protected area where members can view historic statements and track their bonuses.

Soon, they will also be able to order product online. Most importantly, there will be no extra charge for using this extra internet-based service.

All this sounds great but won't Norton attract too many members to the scheme, which could affect the service individual pharmacies receive?

Not at all. The changes being introduced are designed to make the Advantage scheme even more appealing to existing members and non-members alike. If numbers grow too high, membership will be capped to ensure that outstanding service levels are maintained.

If you are interested in joining Norton Advantage, you are advised to be swift with your application.

For further information about Norton Advantage, call the Advantage Telesales Team on freephone 0800 697311.

NORTON Advantage

Gerard House herbals turns over a new leaf

Peter Black Healthcare will relaunch its Gerard House herbal remedies with a new look in November.

The repackaged range will include Somnus, Herbulax, Water Relief, Skin, Catarrh-eeze, Echinacea & Garlic, Serenity and Reumalex.

The packaging features a 'keyword' under the brand name, to help consumers match their symptoms to the appropriate remedy.

A product manual listing all Peter Black products will be available later in the year.

The products retail from £3.49.

Peter Black Healthcare.
Tel: 01283 228373.

Discontinued by Novartis

Novartis Consumer Health is discontinuing Aller-eze tablets (10, 20) Aller-eze Plus tablets (12, 24), Triominic tablets (12, 30) and Triogesic tablets (12 and 30). Triominic toblets (30) ond Triogesic tablets (12) will still be available until next April.

Novartis Consumer Health.
Tel: 01403 210211.

First Response offers earlier results

Carter-Wallace's First Response Pregnancy Test is to be available with single and double tests for earlier use.

The First Response Early Pregnancy Test is designed to enable women to test for pregnancy up to three days before an expected period.

The test detects the pregnancy hormone hCG in urine. Carter-Wallace says that most women will have enough hCG three days before the expected period for the test to give a positive result.

Clinical research conducted by the company over a three year period in the US supports the instructions for early use.

By learning of their pregnancy sooner, women can begin to modify their behaviour to help protect the health of the foetus.

Retail price is £8.25 for a single test and £10.95 for a double test.

Carter-Wallace Ltd.
Tel: 01303 858828.

No spills from Cannon Rubber

Connon Rubber is using UK terrestriol TV for the first time to promote its Avent non-spill Magic Cup until Christmos. The product's 'mogical' quolities are being odvertised on Carlton (London), Central and West Country TV in *Baby Baby* – o new ten-port doytime programme hosted by recent new mum Melindo Messenger.

Connon Rubber Ltd.
Tel: 01787 267000.

Taking technology to the edge!

Gillette is introducing Comfort Blades across its entire twin-blade razor range.

Comfort Blades incorporate key elements of the blade technology used for MACH3, which is said to provide enhanced performance with improved shaving comfort.

The blades combine a thinner blade-profile with a platinum-chrome coating and are designed to have a better edge than traditional Gillette blades.

SensorExcel, Sensor, Contour GII and Blue II are being relaunched with new packaging graphics and the Comfort Blades quality seal guarantee.

Gillette UK Ltd.
Tel: 020 8560 1234.

SB rallies the troops for the fight against flu

SmithKline Beecham is launching new initiatives designed to maintain brand awareness for Beechams throughout the cold and flu season.

A new web site *beechamsfightback.co.uk* offers comprehensive information on colds and flu. It features sections such as 'The enemy and us' and 'Power to fight back' covering causes, symptoms, the body's natural defences and specific ways to prevent and treat colds and flu.

The web site includes the Beechams Cold & Flu Scale, which tracks cold and flu incidence nationally, giving a risk assessment for each region.

Beechams is sponsoring the GMTV regional weather until mid-March. This will enable the company to provide information on flu risks, and ensure that Beechams is brought to the public's attention four times each weekday morning.

- SB is sponsoring the Cold and Flu Council – a panel of experts in fields relating to colds and flu. Consumers can access the panel's independent advice on *coldandflucouncil.org* or via the Beechams web site.

The material is also available as an information leaflet which will be distributed by Beechams as sponsors of the Cold and Flu Council.

SmithKline Beecham Consumer Healthcare UK.
Tel: 020 8560 5151.

ON TV NEXT WEEK

Anadin Ultra: GTV, STV, B, G, Y, C, A, HTV, TT, C4, C5

Askit: GTV, GMTV, C4, C5

Calpol: All areas

Colgate Fresh Confidence toothpaste: All areas

Ibuleve Maximum Strength: C4

Macleans toothpaste: All areas except U, CTV

Multibionta Advanced Formula: ITV, C4, C5, Sat

Poli-Grip: GTV, U, STV, B, G, Y

Seven Seas Cod Liver Oil: G, Y, C, LWT, CAR, TT, C4, C5, Sat

Wella Viva long lasting colour: All areas

Yariba: All areas

A Anglia, **B** Border, **C** Central, **C4** Channel 4, **C5** Channel 5, **CAR** Carlton, **CTV** Channel Islands, **G** Granada, **GMTV** Breakfast Television, **GTV** Grampian, **HTV** Wales & West, **LWT** London Weekend, **M** Meridian, **Sat** Satellite, **STV** Scotland (central), **TT** Tyne Tees, **U** Ulster, **W** Westcountry, **Y** Yorkshire

IN BRIEF

NiQuitin compensation

SmithKline Beecham is reducing the price of NiQuitin CQ Original nicotine patches and the newer Clear patches (last week's *C&D*). The two-week kits for both products will drop in price from £35.95 to £32.95, while the one-week kits will cost £17.49 instead of £19.95. SB is offering compensation to pharmacies for stock bought at previous price levels and not sold by October 16.

SmithKline Beecham Consumer Healthcare UK.
Tel: 020 8560 5151.

NHS Plan

Pharmacy in the future: what's in store?

Over the next few weeks *C&D* will examine in more depth the Government's strategy for pharmacy in the NHS. We will ask key figures how they view proposals set out in 'Pharmacy in the Future – Implementing the NHS plan'. We start with section 2 on better access to services

In the new NHS, the Government says pharmacists will spend more time focusing on the clinical needs of individual patients, helping them to stay healthy, deal with minor illnesses and get the most out of their medicines.

Support for self-care, one-stop primary care centres, access to medicines out of hours, repeat dispensing, electronic prescribing and e-pharmacy are proposed as ways to build on pharmacy's strengths and give patients better access to services.

Supporting self-care

● *The Government will continue to encourage medicines manufacturers to apply for non-prescription status for their products.*

The Proprietary Association of Great Britain is looking closely at the implications of the Government's wish to make a wider range of OTC medicines available.

Executive director Sheila Kelly comments: "The most successful [POM to P] switches are for new indications. With emergency hormonal contraception now going through the system, there is a clear signal that an indication considered suitable only for doctors to manage will not necessarily be a barrier to switching.

"We are delighted that the Government has, for the first time, formally committed itself to self-care and recognised the valuable role played by self-care and pharmacy in the NHS."

● *By 2002 all NHS Direct sites nationally will be able to refer callers to a pharmacy.*

Georgina Craig, the National Pharmaceutical Association's head of professional development, thinks the date of 2002 will be feasible.

"After all, pharmacy referral is what we've been working for," she says. The pilot in Essex finishes next year and she can see no reason why the programme should not be rolled out nationally after that.

● *There will be further opportunities for pharmacists to become involved in health promotion, such as specialist smoking cessation services.*

Georgina Craig says the NPA's biggest bugbear is that nicotine replacement therapy will be on prescription and potentially GSL, which is a missed opportunity for pharmacists to be given an early role in NRT prescribing.

"Getting smokers to obtain NRT on prescription will just clog up GP surgeries," she says. It would make more sense to build on pharmacy's strengths instead.

The NPA intends to work with pharmacists in health action zones and other areas to see what alternative schemes could be piloted.

The Government is particularly keen to target pregnant women smokers, she adds. "Pharmacists see them at an earlier stage than any other health professionals – even before they know they are pregnant, and are buying pregnancy tests. So there are further opportunities here.

"There's also a need to consider how we deal with people for whom NRT is recommended outside the terms of its licence, such as those with coronary heart disease." At present pharmacists might supply such people with NRT on vouchers at the request of a smoking-cessation specialist, but who takes the responsibility? The NPA will be looking at shared-care approaches with good follow-up systems.

● *Pharmacists will continue to play a major role in services for drug misusers, particularly in the supervised consumption of methadone.*

Liverpool LPC secretary Jeremy Clitherow, who has considerable experience of treating drug misusers, welcomes this part of the strategy.

"If the Government is willing to pay for the supervised consumption of methadone in community pharmacies we'll be able to stop the inexorable drift of methadone on to the streets," he says. "But our political leaders must make sure any new services for drug misusers are equitably funded by new money."

One-stop primary care centres

● *Co-location of pharmacies and GPs is one way of fostering better co-operation between doctors and pharmacists for the benefit of their shared patients.*

● *The Government expects to see community pharmacies in a 'substantial' number of the 500 new one-stop primary care centres to be set up by 2004.*

The NPA and Pharmaceutical Services Negotiating Committee are both forming sub-groups to look in detail at various aspects of 'Pharmacy in the future'. PSNC chairman Wally Dove says: "PSNC will have to find out from Department of Health officials exactly what the government has in mind and how contractors fit in to plans for one-stop centres."

Care would be needed not to disrupt the existing pharmacy network, and it would be wrong of the Government to 'cherry pick' the well-sited contractors or large pharmacy chains, he believes.

Access to medicines out of hours

● *Health authorities will be required to review local arrangements, in partnership with NHS Direct, primary care trusts, local pharmacies and patient representatives.*

● *Wherever possible, patients who need to start taking common medicines out of hours should be able to obtain them at the same time as the consultation.*

Wally Dove says it will be important for LPCs to assess local arrangements and see how they can be improved where necessary. One problem is that many out-of-hours GP co-operatives do not generate enough prescriptions to justify setting up a pharmacy service.

Repeat dispensing

● *Repeat dispensing schemes will be in place nationwide by 2004, with many people benefiting as early as 2002.*

John Dixon, project manager for the PSNC's medicines management pilot, says there is potential for repeat dispensing and medicines management projects to work together, as they have a natural affinity. Patients with coronary heart disease, the first group to be targeted in PSNC's pilot, are likely to be on regular medication.

To have repeat dispensing schemes in place nationwide by 2004 is an ambitious target, he adds. "It will need considerable investment in technology, and strong management, to make it work."

Wally Dove agrees that a full-blown repeat dispensing service is unlikely to come into effect before a coherent IT structure is in place.

The NPA's Georgina Craig says repeat dispensing creates a platform for medicines management interventions and electronic prescribing will facilitate its introduction. Repeat dispensing will limit the scope of NHS Direct in ordering medication for patients and counselling on compliance. It will reduce the threats from one-stop health centres; during the NPA/PSNC repeat dispensing study people tended to use a pharmacy near to their home rather than the one nearest the health centre.

e-pharmacy

● *If proper safeguards and professional standards are in place, there is no reason in principle why medicines should not be sold or dispensed electronically.*

The Royal Pharmaceutical Society agrees in principle and has already issued professional standards for the provision of on-line pharmacy services. Its core requirements are that:

● patients' freedom to choose where to have their prescriptions dispensed is protected, and they are aware of the pharmacy's identity

● the source of the electronically-transmitted prescription can be verified, that is, it came from a practitioner authorised under the Medicines Act

● the integrity of information transmitted is protected

● confidentiality is ensured by encrypting sensitive information

● a pharmacist assesses all prescriptions and medicine requests for suitability

● patients or carers receive all information necessary for correct administration

● medicines are delivered safely and promptly, under appropriate storage conditions.

The Society recognises that there will be occasions when e-pharmacy is not appropriate and "is committed to ensuring that e-pharmacy services protect patients' interests".

PSNC chairman Wally Dove says it will be important to consider ways of involving single-handed proprietors or small pharmacy groups who do not have 'Big Brother' looking after them. A way to ensure professional standards would be to introduce some form of accreditation for pharmacy web sites.

Electronic prescribing

● *By 2004 electronic prescriptions will be routine. In most cases, transfer of prescription data between GPs, pharmacies and the Prescription Pricing Authority will be carried out using the NHSNet by 2008 or even earlier.*

The pharmacy e-business sector has already responded positively to this proposal (*C&D* September 23, p41). Allcures.com, Pharmacy2U, NDC Health Information Services and PharMed have expressed interest in running pilots for electronic prescription-transfer.

The NPA's Georgina Craig says electronic prescription transfer would enable community pharmacists to manage repeat dispensing more effectively, together with patient referral from NHS Direct or walk-in centres. Electronic prescribing will facilitate the development of e-pharmacy services, and the NPA will be working to ensure a level playing field for all contractors.

PHARMACY update

Jelly junkies

The benzodiazepines were hailed as a welcome replacement to the older barbiturates, but they are still abused and can cause dependence. Dr Rod Tucker explains

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1179), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* NOVEMBER 11, PROVIDES ONE HOUR'S CONTINUING EDUCATION

OBJECTIVES

- To appreciate the extent of benzodiazepine misuse
- To understand how benzodiazepines are misused
- To understand how the drugs work and cause dependence
- To be aware of withdrawal management procedures
- To be able to advise patients on their safe, effective use

Use of temazepam capsules by drug abusers was first recognised in Glasgow in the mid-1980s. But as early as 1984 there were reports of users in Manchester injecting flurazepam (Dalmane) to intensify and prolong the effects of heroin.

The reason why users turned to temazepam is unclear, although at the time heroin was in short supply and many users may well have sought alternative injectables. Temazepam could be obtained from at least three different sources:

- it was legitimately prescribed as a sleeping aid to users attempting self-withdrawal
- more commonly, the drug was stolen from pharmacies during a break-in
- the drug could be obtained by diversion from legitimate prescriptions, and there have been prosecutions of elderly people who have sold their capsules.

In 1989, the manufacturers of temazepam responded to the problem by changing the formulation so that the practice of withdrawing the liquid centre out of the capsule with a syringe was no longer possible. However, the ever resourceful and determined injectors soon discovered that the gel would dissolve if the capsules were heated; this could then be mixed with water and injected.

Others simply added boiling water to the gel, shook the syringe and injected the mixture once the solution cooled. Once in the veins, the gel would re-solidify and cause a number of complications (see later), the most serious of which was vein blockage. While injection of benzodiazepines was the main route of misuse, there have also been reports of users snorting the drugs after crushing up the tablets.

Despite the manufacturers' response, a survey of 208 users conducted in 1992 found that 59 per cent had injected temazepam capsules, 23 per cent the tablets and 19 per cent had actually injected the syrup. In addition, a quarter of those surveyed had injected diazepam capsules and tablets. A smaller proportion had injected other benzodiazepines such as nitrazepam, lorazepam and chlordiazepoxide. The study's authors commented that banning temazepam, while potentially effective for reducing illicit use, would simply result in users resorting to other benzodiazepines.

In 1996, in response to the growing evidence of misuse of temazepam capsules, the Government took the unusual step of blacklisting the capsules. The sole manufacturer of the capsules, RP Scherer, which stood to lose considerable revenue due to the ban, made an attempt to overturn the ban in the High Court. It argued that the drug should not be restricted due to misuse by some addicts.

The extent of misuse

The actual prevalence of illicit benzodiazepine use is unknown,

Continued on PII →

Continued from PI

though some insight can be gained by examining several different sources. There is no illicit manufacture of benzodiazepines and all supplies are met either by burglaries or by diversion from legitimate sources.

Latest data from the British Crime Survey (1998), which collects confidential information on drug misuse, showed that 3 per cent of the adult population reported having used benzodiazepines. Use tends to be more common in women than men and increases with age, being more prevalent in those over 35.

The regional drug misuse database (RDMD) collates information on people presenting to drug services throughout England and is updated twice yearly. The latest report (to March 1999) shows that use of benzodiazepines as a main drug is reported by only 3 per cent of users.

However, when all drug misuse is considered, benzodiazepines are reported by 16 per cent of users – a figure that has remained relatively constant over the past four years. Though the main drug of misuse for only a small proportion of users, benzodiazepines are reported as a subsidiary drug by 88 per cent of clients.

There is some national variation in benzodiazepine misuse and it has been a particular problem in parts of Scotland. The Scottish drug-misuse database collates information in much the same way as the RDMD, and latest figures (1998-99) suggest that 8 per cent of clients (nearly three times the figure for England) report benzodiazepines as their main drug. When all drug misuse is considered, 14 per cent of clients admit using benzodiazepines.

Since the introduction of the prescribing restrictions in 1996, there has been a change in the use of benzodiazepines, as shown in Figure 1. This graph, which relates only to Scotland, suggests that the prescribing restrictions have not affected benzodiazepine misuse *per se*; users have simply turned to using another drug within the same class instead.

This change in misuse appears to reflect the change in prescribing behaviour since the restrictions were introduced, as shown in Figure 2. There also appears to have been a similar trend in prescribing of both drugs in England, as shown in Table 1.

While prescribing data does not reflect illicit use directly, a fall in the availability of a drug will ultimately impact on its misuse. Unfortunately, the RDMD does not record benzodiazepines separately and hence it has not been possible to make similar comparisons or to draw any firm conclusions about the patterns of benzodiazepine misuse in England.

The current level of injecting of benzodiazepines, which appeared to be relatively high in the early 1990s, is not known. Information from the RDMD suggests that those who report benzodiazepines as their main drug have only injected them in about 3 per cent of cases.

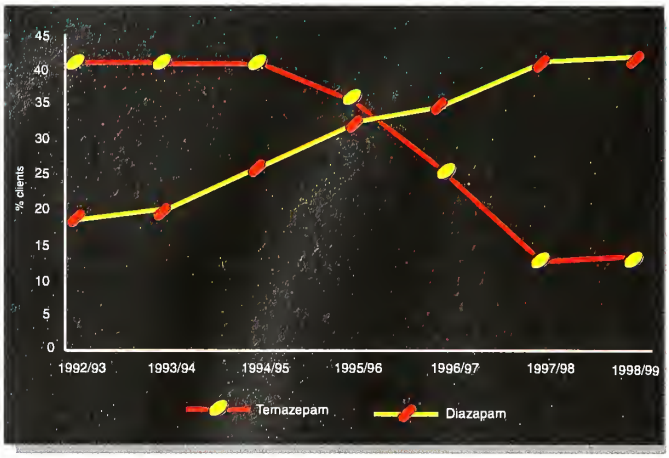
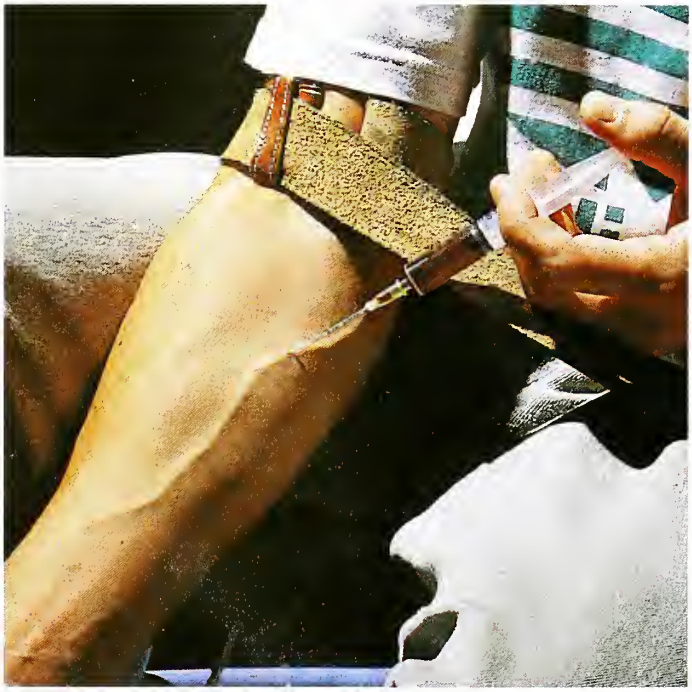


Figure 1. Change in reported drug misuse for clients attending services in Scotland (source: Drug misuse statistics, ISD, 1999)



The majority of users who inject temazepam do so in conjunction with heroin or Temgesic to enhance the rush

How benzodiazepines are misused

Temazepam capsules (both 10mg and 20mg strengths) have a variety of street names including 'wobbly eggs', 'jellies', 'temmazies' and 'duck eggs'. Misuse of capsules is now rare due to lack of availability, though anecdotally users have reported obtaining supplies from abroad.

The cost of temazepam tablets varies between £1.00 and £1.50 each, making the illicit sale of these drugs (given that their manufacturing cost is only a few pence) very profitable. Typically, users will take two or three capsules (sometimes more), often with alcohol. Some injectors have reported using up to 3,600mg daily, although 80 capsules (800mg) per day is more usual. Nitrazepam and diazepam 5mg are also available on the black market, with prices varying between 50p for diazepam and up to £1.00 for nitrazepam.

The majority of users who inject temazepam do so in conjunction with heroin or Temgesic to enhance the rush. Others take it for the sedative effect and to relax

Continued on PIV→

Hypnotics and anxiolytics – a brief history

There are various strategies aimed at managing insomnia, though for many patients drug treatment has become the most convenient option. Historically, the earliest hypnotics were anaesthetics and included bromide salts (sodium or potassium) and chloral derivatives such as chloral hydrate, which was first used in 1869.

The next development came with the barbiturates and in 1903 the first derivative, barbitone, was introduced. The barbiturates were considered to be much safer and more effective than the chloral derivatives.

However reports of fatal poisonings, coupled with the observation that repeated use led to dependence soon blighted the hopes for these drugs. Several of the barbiturates are still in use today and they have had Controlled Drug status since 1985 – some 40 years after the first reports of abuse began to appear.

A new class of anti-anxiety drugs appeared in the 1960s, based on a different chemical structure – the benzodiazepines. Hoffman La-Roche introduced chlordiazepoxide (Librium), the first compound in this group, in 1960. Three years later the company introduced a second drug, diazepam (Valium).

These new drugs were perceived as being effective anxiolytics with fewer side effects, less toxic than the barbiturates, and far less capable of causing dependence. Newer and more effective derivatives were introduced over the years, with the number of prescriptions for benzodiazepines peaking at 30 million in 1978-79. But by 1998, this figure had fallen to 13 million and has remained relatively static for the last five years.

The early 1990s saw the introduction of newer hypnotic agents such as zopiclone, zolpidem and more recently zaleplon. These drugs are promoted as being the safest hypnotics currently available but are not without problems such as dependence. Patients can also experience withdrawal symptoms when trying to discontinue the drug. Perhaps more worrying are reports that zopiclone is becoming popular with drug misusers.

The benzodiazepines themselves are not without problems, a fact first recognised in 1964 by the World Health Organisation when it acknowledged that chlordiazepoxide was could producing dependence of the barbiturate type. By 1998, the Committee on Safety of Medicines reported that benzodiazepine dependence was increasingly worrying and suggested that such drugs should be only be prescribed for a period of two to four weeks.

Reach for the best

Established in 1938 to meet the needs of retail pharmacists, BCM Specials is now the premier Specials supplier in the UK.

We are the best because we hold true to our founding principles, namely to supply quality Specials in the shortest possible time.

With its unrivalled range of formulae and its 'state of the art' facilities there is little BCM Specials cannot provide.

To meet your need for quality, range, speed of service and flexibility BCM Specials is the best option.

BCM Specials putting your patient first.

www.bcm-specials.co.uk

Continued from PII

after taking ecstasy. However, in non-anxious users, temazepam does not induce feelings of wellbeing and is rarely used alone. Interestingly, users have been known to experience paradoxical effects, for instance they feel less inhibited and are talkative and excitable.

Temazepam can make users feel violent and aggressive, and is also reported to produce memory loss and blackouts. Many people have described a sense of invulnerability, which has led to them feeling that they are invisible and given them the confidence to shoplift.

Research also shows that temazepam users are more likely to indulge in AIDS-related risk behaviour such as sharing syringes and having unprotected sex.

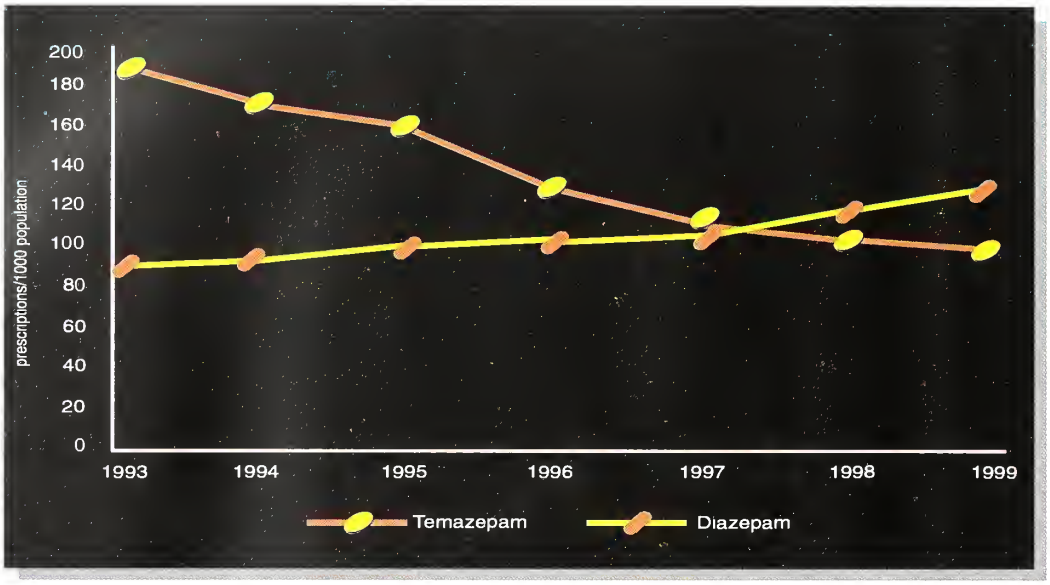


Figure 2. Prescriptions per 1,000 population in Scotland for year ending March 1999 (source: Drug misuse statistics, ISD, 1999)

Table 1. Number of prescriptions for diazepam/temazepam dispensed in England

	Prescription items (000s)					
	1994	1995	1996	1997	1998	1999
Diazepam	3,288	3,410	3,600	3,798	3,989	4,107
Temazepam	6,345	6,063	5,540	5,252	5,043	4,878

(source: PPA, June 2000)

Table 2: Dose equivalents for commonly used benzodiazepines

benzodiazepine	Dose equivalent to 5 mg diazepam
chlordiazepoxide	15 mg
loprazolam	0.5 mg
lorazepam	0.5 mg
oxazepam	15 mg
temazepam	10 mg
nitrazepam	5 mg

(Source: DoH, 1999 guidelines)

The injection of temazepam and other benzodiazepines has been associated with several problems such as local abscesses, tissue necrosis (as temazepam is irritant to tissue) and deep vein thrombosis. Injection of the tablet form can lead to blockage of veins by the inert fillers in the formulation. This has led to amputations.

Benzodiazepines and the law

As the law stands, unauthorised possession of benzodiazepines is illegal and it is illegal to pass them on or sell them to another person. The person who receives the drugs, however, will not be prosecuted. All the benzodiazepines are Schedule three (Class C) drugs, although in 1992, the Advisory Council on the Misuse of Drugs recommended that temazepam be moved to Schedule two. At present temazepam is a Schedule three Controlled drug and since April 1996, pharmacists have been required to store temazepam in a safe along with other Schedule two drugs.

Mode of action

In 1975 it was discovered that benzodiazepines interact with the GABA (gamma aminobutyric acid) receptor. GABA is an inhibitory neurotransmitter: as levels of GABA are increased, brain activity decreases.

Benzodiazepines bind to the $GABA_A$ receptor ionophore to increase chloride ion conductance and hence increase the effects of GABA. This effect can be blocked by benzodiazepine antagonisers such as flumazenil.

Depending on the neural circuitry involved, enhanced GABA activity can give rise to an anxiolytic, hypnotic or anticonvulsant effect. And in fact certain benzodiazepines (eg diazepam, and clonazepam) are used in the treatment of epilepsy.

However, studies appear to indicate that the benzodiazepine-GABA receptor has at least three different groups, which can exist in different forms. It also appears that the newer anxiolytic drugs such as zopiclone possibly bind to different parts of the same receptor complex.

Benzodiazepine dependence

Long-term use of benzodiazepines leads to tolerance and dependence. The nature of benzodiazepine dependence is poorly understood, although several theories have been advanced.

One such theory involves the concept of an endogenous benzodiazepine ligand, even though no such compound has ever been isolated. Other theories, for which there is some experimental evidence, suggest that changes occur in the density of the GABA receptors.

After continual use, the benzodiazepines lose their effectiveness, possibly by down-regulation of the GABA receptors. This has been shown in experimental animals, where continuous administration of benzodiazepines has effectively desensitised the GABA receptor and enhanced the effects of inverse agonists (ie inducing opposing effects).

A well-recognised withdrawal syndrome does exist and produces a number of rebound effects such as anxiety, depression, insomnia, tinnitus and paraesthesia (pins and needles), as well as visual disturbances and flu-like symptoms. These withdrawal effects can be induced in long term users, particularly with the shorter acting drugs such as temazepam, in as little as 24 hours. Longer-term effects include various psychological effects such as hallucinations, paranoia, depression and apprehension.

Several factors are important in development of the withdrawal syndrome. Clearly, the most important factor is duration of drug treatment. However, dosage is clearly another important factor; animal studies show that physiological dependence can be induced at high doses. Since drug abusers often consume very large doses, it is likely that some form of physiological dependence is inevitable.

The theory that dependence is purely psychological does have some currency, as does the notion of the dependence-prone personality. However, many people have ascribed the rebound effects induced by withdrawal as simply a return to the individual's original mental state.

Treatment of benzodiazepine misuse

While methadone can be used to withdraw patients from illicit opiates, there is no specific drug treatment available for benzodiazepine-dependent individuals. The two key features

Continued on PVI

Paracetamol, Phenylephrine, Caffeine.

We're looking at Nasal Health in a whole new way.

From the inside out.

Sudafed is about to make its TV debut with advertising that looks at nasal congestion in a completely different way. The three month national campaign also introduces new Sudafed Dual Relief, for congestion and the sinus pain that it can cause. To help build the importance of good nasal health and confirm Sudafed's status as doctors', pharmacists' and counter assistants' favourite decongestant brand, we're also launching an educational campaign with a new CD-ROM training package, available through your Territory Manager. So, if you want your customers' noses to be clear, there's a clear choice.

Long-term effects of benzodiazepine misuse includes depression

Continued from PIV

of the treatment strategy involve a gradual reduction of dosage, and anxiety management.

As the only real difference between the benzodiazepines is in their half-lives, it has become standard practice to change the patient to an equivalent dose of a longer-acting benzodiazepine such as diazepam. This policy has been recommended in the recently published guidelines on the management of drug misuse produced by the Department of Health.

Equivalent doses of diazepam for some of the other benzodiazepines are shown in Table 2.

The advantage of changing to a longer-acting agent is that it allows for a more gradual dosage reduction. The conversion to diazepam can be used successfully for patients' prescribed therapeutic doses, as well as those taking very high doses as shown in the box.

Managing benzodiazepine withdrawal

- Having converted the patient to an equivalent dose of diazepam, reduce the dose by about 10 per cent per month provided the patient is stable and remains free of withdrawal symptoms. Sudden cessation of high-dose benzodiazepine use can result in convulsions.
- If the patient is stable on 60mg diazepam, reduce by 5mg per month and then review again after six weeks.
- For patients stable at even higher doses, eg 100mg diazepam, reduce the dose by 5-10mg monthly.
- If a patient is stable on a much lower dose, such as 20mg diazepam, then reduce by 1-2mg monthly.
- Continued review is vital (at least every three months) to ensure that patients remain stable after dose reductions. If patients became unstable, ie they begin to experience withdrawal symptoms, the rate of dose reduction should be slowed down. Complete withdrawal can take up to a year.
- If a patient is co-prescribed methadone, the dose should remain constant while the benzodiazepine reduction takes place.

C&D is accredited by the College of Pharmacy Practice as a provider of distance learning until March 2001.

ACTION PLAN

1. In your practice workbook list the next 100 patients prescribed a benzodiazepine. Divide the list into anxiolytics and sedative/hypnotic uses. Now note those patients who you think are misusers. How many of these are undergoing dosage reduction?
2. Of these misusers, try to assess how many are male/female and how many (particularly of those taking the 'sleeping' drugs) are young/elderly?
3. Do you think the benzodiazepines are prescribed too frequently? Is one particular doctor involved? Can you do anything about it?
4. Have you noted any switch to the newer benzodiazepines (zopiclone, zolpidem, and zaleplon)? Do your patients comment on their changed drugs?

Coming up to scratch?

Most people will catch chickenpox as a child. But the virus lays dormant in nerve tissue and, if reactivated, results in shingles. Steve Bremer looks at the varicella-zoster infections

Almost everyone has had it by the time they reach adulthood. It is highly contagious. About 90 per cent of people in a household who have not previously had it will catch it if exposed to an infected family member. Chickenpox is usually mild, but it can cause death in infants and adults with impaired immune systems.

Chickenpox is caused by the varicella-zoster virus (VZV), which is spread from person to person by direct contact or by droplets in the air from sneezing or coughing. The virus is similar to the herpes virus, and to the Epstein-Barr virus, which causes mononucleosis.

Each year in the US 5-9,000 hospitalisations and 100 deaths are caused by the infection. The greatest number of chickenpox cases occurs during the late winter and spring.

The first symptoms are fever and malaise, followed by the typical rash. The 'poxes' start as small red spots, which become red bumps and then develop a small vesicle of clear fluid in the centre.

Eventually the vesicle breaks, the pox crusts over, dries, and falls off. New crops of blisters erupt for up to five to seven days. The rash usually appears first on the head, often along the hairline, then spreads over the entire body in successive crops of new poxes.

An infected patient may have from anywhere between just a few lesions to over 500, but the average is 300-400. Eruptions mainly occur on the trunk and limbs, but can appear almost anywhere, including inside the mouth, nose, throat and vagina.

An infected child is thought to be contagious from one to four days before the rash appears, until all the poxes have crusted over. However, there is some evidence that a child is no longer contagious six days after the rash starts. Symptoms develop between ten and 21 days after contact with an infected person.

A newborn baby is protected for several months from chickenpox if the mother had the infection prior to, or during, pregnancy. This immunity diminishes in four to ten months.

Complications are rare in children, but are more likely in infants, adults, pregnant women, and the immunocompromised. They can include:

- secondary bacterial infections
- pneumonia
- encephalitis
- cerebellar ataxia
- transverse myelitis
- Reye's syndrome (administration of salicylates to children with varicella increases the risk of Reye's syndrome)
- death.

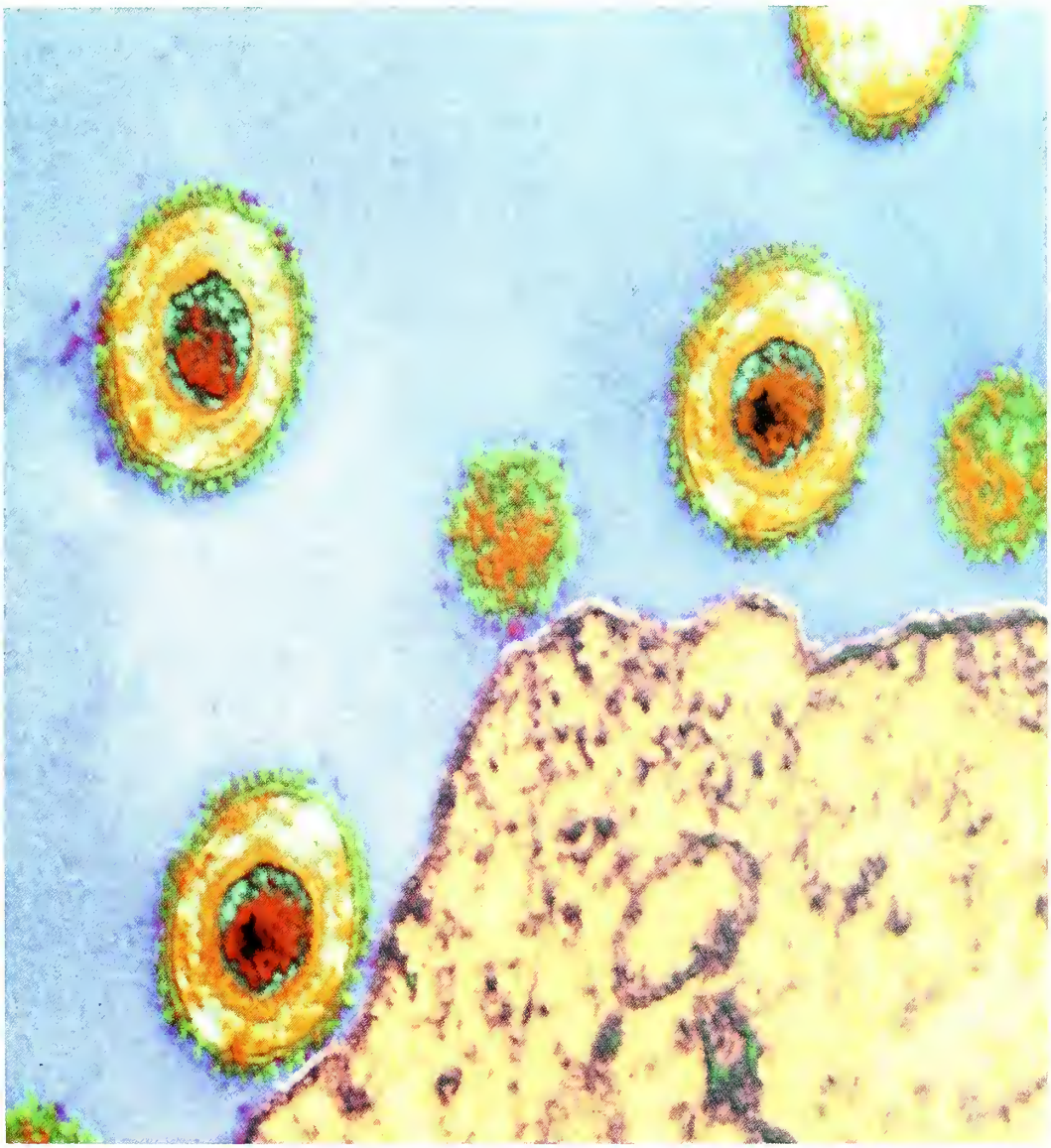
Diagnosis is usually made by the appearance of the skin eruptions. Laboratory tests are not necessary.

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1180), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* NOVEMBER 11, PROVIDES ONE HOUR'S CONTINUING EDUCATION

OBJECTIVES

- To recognise the symptoms and complications of chickenpox
- To be familiar with treatment options for chickenpox
- To appreciate the link between chickenpox and shingles
- To recognise shingles symptoms
- To be able to advise patients on shingles treatments



Eye of Science/Science Photo Library

Varicella-zoster viruses cause chickenpox and shingles

By intravenous infusion, the dose is 5mg/kg every eight hours, usually for five days. This is doubled to 10mg/kg in the immunocompromised.

Varicella-zoster immunoglobulin is recommended for individuals at risk of severe varicella who have no varicella-zoster antibodies, and who have significant exposure to chickenpox or herpes zoster. Those at risk include neonates of women who develop chickenpox seven days before or 28 days after delivery, women exposed at any stage of pregnancy, and the immunocompromised. The immunocompromised group includes those who hove received a high dose of corticosteroids in the previous three months.

Varicella vaccine is available on a named-patient basis from SmithKline Beecham or Pasteur Merieux.

Shingles

Most people who have had chickenpox will be immune to the disease for the rest of their lives. However, the virus remains dormant in nerve tissue, and may occasionally revert to its infectious state. It is usually held in check by cell-mediated immunity, but if this declines the virus may reactivate, causing herpes zoster, or shingles.

Factors that reduce CMI, and therefore cause reactivation, include:

- normal ageing (about half of people aged over 80 will develop shingles)

Continued on PVIII →

Management and treatment

Treatment is aimed at relieving symptoms. General measures include:

- cool water soaks or compresses can reduce itching
- patients should be kept as cool as possible to reduce irritation triggered by heat and itching
- nails should be kept short to discourage scratching, which can lead to secondary infection.

Calamine or crotamiton preparations can be used to control itching, although crotamiton should only be used on the advice of a doctor for children under three years old.

Excessive application of topical local anaesthetics should be avoided as they can sometimes be absorbed. They are not generally suitable for young children. They are not recommended for more than three days use, and may cause hypersensitivity. The *BNF* considers topical anaesthetics 'less suitable for prescribing'.

Topical antihistamines are also considered by the *BNF* to be less suitable for prescribing. They can cause hypersensitivity and should be avoided in eczema. Photosensitivity reactions can occur with diphenhydramine. Topical antihistamines are not recommended for more than three days' use.

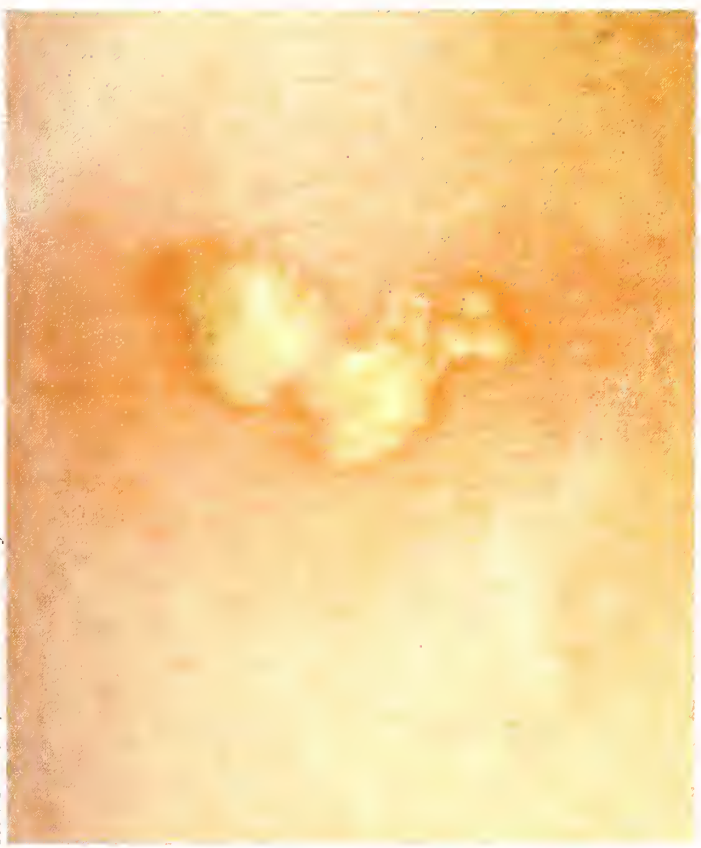
Oral antihistamines can reduce the itching associated with chickenpox. The older, sedating variety may be particularly useful for calming children.

Paracetamol may be given to relieve fever and pain.

Aciclovir is effective against the herpes viruses but does not eradicate them. It is effective only if started at the onset of infection. It can be life saving in varicella-zoster infections in the immunocompromised.

It can also be given by mouth to immunocompetent adults and older adolescents with chickenpox, but is not generally indicated for immunocompetent children.

Oral dosage in adults is 800mg, five times daily for seven days. In children it is 20mg/kg (maximum of 800mg) four times daily for five days. For the under twos, it is 200mg four times daily, 2-5 years, 400mg four times daily, and in the over sixes, 800mg four times daily.



Scott Camazine/Science Photo Library

Close-up of a herpes zoster (shingles) vesicle on the knee

Continued from PVII

- disease, particularly Hodgkin's disease
- physical or emotional stress
- fatigue
- poor nutrition
- chemo- or radiation therapy.

Once reactivated, the virus travels along nerve fibres, usually settling in isolated areas of skin on one side of the body. The infected area usually has severe pain, itching, redness, numbness, and a rash.

Prodromal symptoms of mild chills and fever, general malaise, mild nausea, abdominal cramps or diarrhoea may be present for three or four days before distinctive disease features develop. Characteristic fluid filled vesicles appear on about the fourth or fifth day.

The vesicles appear on a broad streak of reddened skin along sensory nerve routes to a particular area of skin. They most often occur on the chest. The zoster eruption is unilateral, and does not cross the midline.

Most commonly affected regions are those supplied by the trigeminal nerve and thoracic ganglia. These areas include those around the chest and abdomen, and the eyes.

The vesicles begin to dry and scab about five days after appearing. In severe cases, the rash can leave permanent scars, long-standing pain, numbness and skin discoloration.

Transmission of the virus from patients with herpes zoster to produce chickenpox has occurred, but less frequently than transmission of the virus from chickenpox patients. Precautions are necessary to prevent spreading of infection by direct contact with secretions from vesicles and secretion-contaminated items.

Diagnosis

Though difficult in the preeruption stage, diagnosis is readily made after the vesicles appear in characteristic distribution. Pleurisy, trigeminal neuralgia, Bell's palsy and chickenpox (in children) must be differentiated.

The pain may resemble that of appendicitis, renal colic, cholelithiasis, or colitis, depending on the location of the involved nerve. Herpes simplex may produce nearly identical zosteriform lesions. Herpes simplex tends to recur, but herpes zoster rarely does. The viruses can be differentiated serologically and by culture.

Complications

Shingles complications include secondary infection in the blisters, corneal ulceration, Ramsay Hunt's syndrome, and postherpetic neuralgia (PHN).

Damage to the eye can occur following involvement of the gasserian ganglion, with pain and a vesicular eruption in the distribution of the ophthalmic division of the fifth nerve. A third nerve palsy may be present. Vesicles on the tip of the nose indicate involvement of the nasociliary branch of the fifth nerve and the cornea.

If the shingles rash spreads from the forehead or cheek to the eyelids, it may cause redness of the conjunctiva. And it can also cause scratches on the cornea, or scarring.

These scratches may lead to iritis or uveitis. The optic nerve or retina can also be affected. Severe or repeated infection is associated with glaucoma, scarring inside the eye, and cataracts.

Geniculate zoster, or Ramsay Hunt's syndrome, results from involvement of the geniculate ganglion. Pain in the ear and facial paralysis, which is rarely permanent, occur on the involved side. Vesicular eruptions are present in the external auditory canal and on the auricle, the soft palate, and the anterior pillar of the fauces.

PHN occurs in about 10 per cent of shingles patients and is thought to result from nerve damage caused by the VZV virus. It causes pain after the skin lesions have crusted, which is often severe in areas where the blisters occurred. Affected areas are extremely sensitive to heat and cold.

Risk factors for the development of PHN may include severity of pain, significant sensory impairment, and advancing age. Prompt treatment of acute zoster pain may decrease the incidence of PHN.

Treatment

Aciclovir, famciclovir and valaciclovir are all effective if treatment is commenced at the onset of infection. Treatment should be within 72 hours of the rash first appearing.

The dose for aciclovir in shingles is the same as in chicken pox. Famciclovir can be given at doses of either 250mg three times daily for seven days, 750mg once daily for seven days, or 500mg three times daily in immunocompromised patients. Recommended dose for valaciclovir is 1g three times daily.

Aciclovir is also available as a cream and eye ointment. A cream containing penciclovir has recently been launched. Idoxuridine in dimethyl sulfoxide application is deemed to be of little use by the *BNF*.

Attempts at preventing the development of postherpetic neuralgia have not been particularly effective, although famciclovir used to treat shingles may decrease the duration of subsequent PHN. Treatment is therefore based on managing the neuralgia.

Amitriptyline may be used early in the acute phase, initially at 10-25mg daily at night, and the dose increased gradually to about 75mg daily, but this is an unlicensed indication.

Where amitriptyline fails to manage the pain adequately, the addition of sodium valproate or carbamazepine may improve control. These drugs are also unlicensed for this indication.

Capsaicin cream is licensed for use in PHN. It should be applied three to four times daily after the lesions have healed. It produces an intense burning sensation during the initial treatment period.

C&D *is accredited by the College of Pharmacy Practice as a provider of distance learning until March 2001.*

ACTION PLAN

1. In your practice workbook note the next 20 cases of chickenpox/shingles you encounter. How many patients with these conditions were prescribed an antiviral drug? Think about why antivirals are not prescribed for all cases.
2. Develop a protocol for giving advice to people who develop chickenpox. It should concentrate on advice you would give to mothers of young children – the largest 'at risk' group.
3. Revise your knowledge of the period during which patients with either chickenpox or shingles are contagious.
4. In your practice workbook note the problems associated with recognising these conditions in the initial stage. Can you recognise these conditions?
5. In your practice workbook note the more serious problems associated with the varicella/zoster viral infection. How would you recognise these problems? What advice would you give to the patient to ensure they were aware of these problems and how they should react?

PHARMACY update: distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, *C&D*'s readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the November 11 issue, which will cover this week's CPP-accredited modules, together with those in the October 7 issue.

In other words:

- Emergency contraception (1178)
- Benzodiazepines (1179)
- Varicella-zoster (1180).

A faxback service for these modules and associated MCQs operates on 0891 444791 (premium rates apply). A telephone marking service offers independent verification of results – details are given on the monthly MCQ papers.

C&D in association with

GENUS PHARMACEUTICALS

A well-stocked village pharmacy has the advantage of being next door to a surgery, but it is failing to sell enough toiletries and related items to local residents. John Kerry reports

Attracting the locals

Certain well-known essential ingredients are needed to ensure the success of a new community pharmacy practice. Without a good location, a population of 4,000 or more and at least two practising GPs, it could be hard work.

Mrs T had these three ingredients plus a few more when she opened her pharmacy in 1993. Her shop was in a new shopping precinct at the heart of an established village, whose population had more than doubled in size in recent years to 5,500; her new 1,000ft² unit was right next door to a surgery which had two full-time GPs and one part-time. To crown this there was no opposing pharmacy for miles, so Mrs T had a fertile greenfield site to develop just the way she wished and that's exactly what she has done.

It's a surprisingly spacious front shop for a village: 800ft² with a 220ft² dispensary and a 120ft² consulting room for good measure. From this luxurious space Mrs T grossed £508,709 last year, up 4.6 per cent on the previous year. Around 85 per cent of this figure is NHS dispensing (£429,250) with £80,000 in counter sales.

The pharmacy has a throughput of 2,500 customers a month, each providing an average of 1.8 script items, but only a sale of £2.66 per customer. Gross profit last year was up 0.9 per cent over the previous year to 23.7 per cent, a good result in the current climate. Admin expenses increased by £20,000 in the same period resulting in a drop in operating profit, which plunged from 8 per cent to 5.58 per cent.

Although Mrs T is pleased with the overall success of her new business, she is concerned about the falling profits and low counter sales. Her accountant will be best-placed to identify the rise in expenses, as a breakdown of this figure was unavailable. From a counter sales point of view it isn't as simple. This shop has always been well-stocked with all the traditional pharmacy merchandise a mixed population would want, bearing in mind it's the most convenient local retailer for these items. Few would argue with this strategy especially as the locals would have to drive a long way to find another pharmacy. However, it appears that most of them do travel to buy their toiletries, baby care and hair care products, because they are not buying much from Mrs T. She admits it is hard enough for an established pharmacy to fight the superstores and multiples, let alone a new one.

The pharmacy is designed to serve 21st century citizens. Mrs T has worked hard to establish a prescription and advice service level second to none. This is no ordinary pharmacy feeding off a nearby surgery's script output, flourishing without any competition. This is the centre for prescriptions, healthcare advice, many diagnostic services, complementary treatment and advice, and it is a valuable part of the community healthcare team, working very closely with the next-door practice.

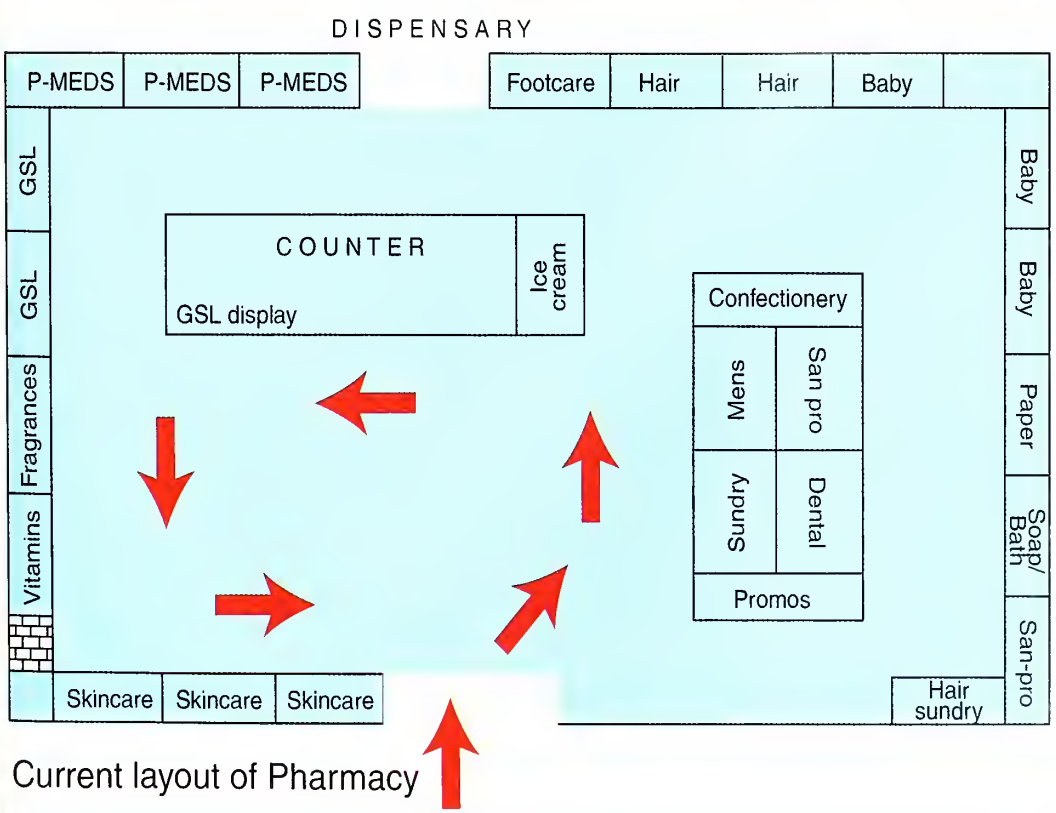
If the pharmacy were in a large town it would have an excellent reputation and a turnover to match. But it isn't, so with a limited potential it has cornered the healthcare market locally – but the patients, who wouldn't go anywhere else for medicines, certainly don't have the same feelings about where they buy their pharmacy products.

How then does Mrs T persuade them to change their buying habits? If you know the answer, please write to *C&D*, because there are hundreds of pharmacists who would like to know how.

On the plus side, this is a good-sized pharmacy, well-fitted, well-merchandised, with competitive prices and as welcoming as any town

Mrs T's pharmacy, profit & loss for the year ending September 30, 1999

	1999 £	1998 £
Turnover	508,709	485,965
Cost of sales	(387,772)	(375,094)
Gross profit	120,937	110,871
Administrative expenses	(92,700)	(72,049)
Operating profit	28,237	38,822
%	5.88	8.0



Current layout of Pharmacy

centre multiple or out-of-town superstore. Parking is free and it's easily accessible to locals. However, the pharmacy suffers from a number of influences beyond its control. Until just over six years ago, most of the region's population had no local pharmacy so they were quite used to driving into town for their needs.

Then, of course, there's the established, but often wrong, impression that an independent cannot possibly compete on either choice or price with multiple outlets. Meanwhile, one-stop shopping is here to stay, or at least it is until people realise that they will have to save at least £5 on their checkout bill at the supermarket to make up the cost of the petrol consumed getting there and back. Even an excellent retailer cannot survive alone in a village without the support of the others.

Although there are other everyday shops which do not appear to be about to close, such as a post office/convenience store, a mini-supermarket and a tiny bakery, the majority of outlets are service and fast food, eg two hairdressers, Chinese take-away and a pizza parlour. It's clear that these retailers are catering for immediate needs, without attempting to win trade away from the big boys. Mrs T, therefore, is not being helped in her quest by her neighbours and is providing for customers' immediate needs for healthcare and prescriptions but very little else. Many of her counter sales will, just like the mini-markets, be for items forgotten on the weekly shopping trip.

Can she change these habits and attitudes? Common sense and experience says no, at least not enough to make the effort worth it. She does, however, have the opportunity to improve the profitability of the counter trade and substantially increase the sales/ft² of her shop.

Recommendations

This pharmacy typically presents two faces to its public. One is a highly-efficient, caring, modern medicine and dispensing service, totally integrated with the healthcare team. The other is a large, smart, well-stocked chemist's shop, providing everything the locals would need from such a retailer, if only they would bother to use it.

However, apart from its convenience, the retail side of this business offers nothing out of the ordinary, nothing to compel the population to change their buying habits and attitudes, no USP.

It makes sense, therefore, to consider adding some excitement to this pharmacy, or at least some new product lines that might interest the locals. Exciting is better, but hard to find. Give them a good reason to visit your shop and they will make the effort. Once you've got them you are likely to keep them. The best reason of all is the pharmacist and the dispensary, but here, like many other businesses, the customers are blinkered and use the dispensing service and little else.

What product ranges should this shop introduce? Many pharmacies in similar situations have done their research locally, discovered what the population wants but is unable to purchase, and simply stocked it. Products such as gifts, greetings cards, gift wrap, fashion accessories, toys, specialist health foods and sports dressings often fill a local need.

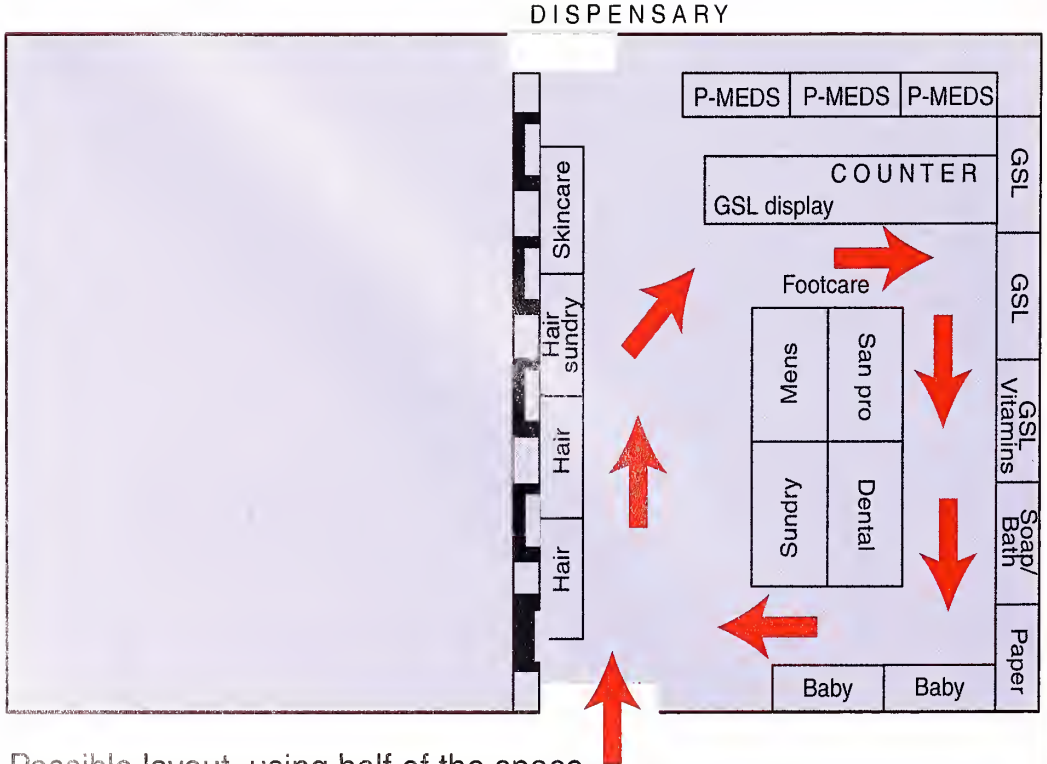
To discover what might be profitably sold in any pharmacy, requires local consumer research and observation. A number of opportunities will present themselves and they should be given a serious try. Any new product range needs publicity, and this would give Mrs T a chance to advertise or do a leaflet-drop with a flier attached.

This pharmacy has another option: Mrs T does not need 800ft² for £80,000 of counter sales per annum. She could do all this and a good deal more from 400ft².

The space saved could easily be used for a new business - a shop within a shop. Again local research will reveal some possibilities. The first that spring to mind are coffee shop, cyber cafe, gift shop. The village doesn't have any of these. Alternatively, the spare space could be separated and let to someone who wishes to take the plunge into village retailing.

Mrs T has created, in just a few years, a pharmacy she can be proud of. She has the strategy just right for the pharmacy and healthcare side and many would be wise to follow her example.

Making the front shop buzz is a different matter. Adding some special ingredient may help to make it more exciting and attract new customers, but if she doesn't mind sacrificing half of the space she should not lose any sales by cutting the shop in two.



Possible layout, using half of the space

SWITCH

TO EASI-BREATHE.

AN MDI THAT DELIVERS

THE CORRECT-METERED DOSE.

AUTOMATICALLY.

THE PRINCE OF WALES AWARD For Innovation

Easi-Breathe®

ADVANCED ACTUATION MDI

Becotide™ Easi-Breathe®
BECLOMETHASONE DIPROPIONATE

Becloforte™ Easi-Breathe®
BECLOMETHASONE DIPROPIONATE

Ventolin® Easi-Breathe®
SALBUTAMOL

Cromogen™ Easi-Breathe®
SODIUM CROMOGLYCATE

SWITCH ON YOU WILL NEED TO ENTER THE PASSWORD 'SWITCH ON' TO LOG ON TO THE SITE.

www.easi-breathe.com

A H

BAKER NORTON

Irene Brackenridge suddenly found herself in a very enviable position – she had just won £40,000 for a much-needed refit after coming up tops in the UniChem 1999 Millennium Promotion. Nina Keller-Henman takes a peek at Irene's 'diary of a refit'

With the new refit, the sales area is clearly visible from the front shop

A fitting reward!

As the owner of Tillydrone pharmacy, Irene Brackenridge has had to face all the usual problems associated with being situated in a deprived area – in Irene's case in Aberdeen. And yet, the first thing one notices when talking to Irene is how dedicated she appears to be to her work and her customers, who include a high percentage of patients on methadone.

Ever since she bought the pharmacy three years ago, Mrs Brackenridge has been dreaming of being able to give Tillydrone a more professional, modern look, but she admits that she never really had the time to see it through.

Now, of course, that has all changed!

The joy of winning

March 2000 *Irene Brackenridge is announced as the winner of the UniChem 1999 Millennium Promotion*

In the process she saw off competition from a large number of other entries to claim the first prize, a £40,000 pharmacy refit. Winning certainly came as a great surprise.

"It was absolutely wonderful, a shock of the most pleasant kind. I felt like it was all birthdays and Christmases thrown in together," says Mrs Brackenridge.

Receiving the telephone call from UniChem telling her the good news is a moment she will never forget, although she confesses that it left her feeling slightly embarrassed.

"Peter Skinner [UniChem's marketing controller] called and I just did not click – I thought it was something to do with our account and so I asked him what I could do for him. He simply said that it was him being able to do something for me. Oops!"

Things could have turned out differently, as Mrs Brackenridge very nearly did not enter at all. It was almost too late when she spotted the competition in November 1999 and then confidently wrote down the catchy tiebreaker 'Year 2K at Tillydrone pharmacy will herald a new era for thinking of "ourshelves" and dispensing with others'.

"It was just a bit of fun at the time," says Mrs Brackenridge.

Fun soon turned into hard work when she was chosen as one of only 18 finalists and found herself having to think very fast and very seriously about why she wanted a refit.

March 3 2000 *The final decision regarding the winner is taken by a panel which included Peter Skinner (UniChem) and C&D editor Patrick Grice, as well as Mike Biggs (Roche Diagnostics) and Steve Hogg (Procter & Gamble)*

"I think Irene showed a great deal of care and compassion towards her local community and her customers. She was very focused on the particular needs of her area and she showed real vision of where she wanted to go with her pharmacy," says Peter Skinner, explaining the reasons behind the panel's choice.

From then on, events moved along at an ever-increasing pace.

Planners move in

March 16 *UniChem shopfitters SGI conduct a thorough survey of Tillydrone pharmacy*

"It was pretty much a straight forward refit," says Steve Grundy, SGI's managing director, adding that: "Our biggest challenge was the size of the premises. There is no office space at Tillydrone and only a small stock room, which caused us some problems."

April 10 *The SGI shopfitters embark on the trip up to Aberdeen to discuss five options for the refit with Mrs Brackenridge*

"We really wanted to make the interior of the shop much more welcoming and open to the public," Mrs Brackenridge says.

It was particularly important to her to improve accessibility to the pharmacy for her disabled customers and drug users.

One of her main objectives was to provide these customers with good healthcare and advice.

She had previously introduced a 'kiosk' for customers taking part in the needle-exchange or methadone programme but admits that it had been done on a shoestring budget.

"The main focus of the refurbishment was to make that area more private and pleasant to work in for both staff and patients."

Mrs Brackenridge says she had been absolutely delighted to find that SGI went to great lengths to incorporate her ideas and to make sure that she was happy with the plans.

Work begins in earnest

"During the refit was a nightmare, but then again it was over very quickly," Mrs Brackenridge says, as she reflected over the past few months.

July 5-8 *The first stage of the refit is about to begin*

"We tried not to affect trade in the pharmacy where this was at all possible," explains Mr Grundy. Due to the lack of space the SGI team decided to decamp to a council-owned property next door, which they rented for the two weeks of the refit. The shopfitters' initial focus was

on the rooms outside the actual pharmacy, such as the stockroom, the lobby and toilet areas. New worktops and a new sink were installed before attention moved to the dispensary.

July 9 and 10 *The dispensary's turn to be refitted*

"Irene was tucked away behind the dispensary," Steve Grundy explains. Before the refit, two steps led up to the dispensing area and the pharmacist's view was blocked by shelves carrying the P-medicines.

Key to SGI's plans was to make Mrs Brackenridge more accessible to her customers. SGI lowered the whole dispensary so that only one step remained and also reduced the height of the P-medicines shelves by 40mm.

"We've made the dispensary slightly smaller, but certainly more efficient," is how Mr Grundy sums up the changes.

The sales area is now clearly visible from the front shop making the pharmacist far more accessible for customers.

"I think it was a bit daunting for her at the beginning, but she seems to have got used to it quite quickly," he says.

A private consulting room featured high on Mrs Brackenridge's priority list for the refit.

"Obviously I had to bear in mind that privacy of the patient has to be balanced with the fact that you as the pharmacist have to be accessible and within earshot all the time," she explains.

SGI shopfitters tried not to affect trade in the pharmacy while the refit took place

This, however, proved to be one of the few of her ideas that was not easily implemented.

According to Mr Grundy: "It would certainly have meant building alterations and we felt it was not really worth going to that stage."

As a compromise SGI included a consultation point at one end of the dispensing counter which now also provides customers with health information in the form of leaflets.

"This semi-private area is working very well indeed," Irene says.

As the refit was running to a very tight schedule, the work on the dispensary was completed by 3pm the next day. Mrs Brackenridge followed suit and came in to remerchandise the dispensary to get it perfect for opening the following day.

July 11-17 *The refurbishment reaches its final stage - the front shop*

This part of the refit saw the methadone dispensing area being transformed completely and the front

Continued on P22 →

→Continued from p21

shop taking on a fresh, modern look. In order to limit disruption to customers, parts of the shop were sealed off at different times during the week.

The carpet was replaced with a fashionable beech vinyl floor and the old shelving units were removed and metal modular shelving units installed in their place. Only the gondola units on the shop floor remained the same.

Anxious not to drive away customers taking part in the methadone and needle-exchange programmes, the SGI team mainly worked on this particular area at night.

To give it a more professional and clinical look, the area was tiled and fitted with a vinyl floor. The SGI shopfitters maintained a completely separate entrance to the area with an electronic buzzer for security reasons.

Because the pharmacy is in a deprived area of Aberdeen, security in general has always been high on the agenda and there is still a CCTV camera outside. Customers are served through a special hatch and the methadone area is clearly visible from the new dispensary through a glass panel.

Success all around

"I think we have managed to achieve the look of a modern day pharmacy without going overboard," Steve Grundy says.

Bearing in mind the pharmacy's location and customer base, he adds, the shopfitters "really needed to try and reach a balance between bringing the shop into modern times while not sending the wrong message to Irene's customers".

"I was absolutely astounded by how professional and helpful the UniChem shopfitters were – it was brilliant," is Irene Brackenridge's verdict.

Merchandisers arrive

September 2000 *After Mrs Brackenridge had had a couple of months to settle into her new look pharmacy, the Moss merchandising team put the final touches to the project*

Top: the Tillydrone pharmacy before the refit. Below: a thrilled Irene Brackenridge

The first thing the merchandisers did was to change categories around in terms of their placement in the pharmacy before merchandising each category.

Mrs Brackenridge feels that the biggest impact has been in the baby category, where the Moss merchandisers introduced UniChem's 'Baby come back' concept.

So has she picked up some useful tips?

Irene Brackenridge is not entirely sure, but is hopeful that she has learned a little something and will be able to recreate it.

"It was really nice to benefit from their experience on this occasion, though – the place looks terrific," she says.

Dramatic but worth it

Mrs Brackenridge sums up the whole refit experience by saying: "While it was going on it was quite dramatic but it's been worth it. I certainly would not have contemplated doing this without the help from SGI, though."

And her last word on the project that transformed her pharmacy? "I am thrilled to bits," she told *C&D*.

NAME

Age if under 12 years
yrs. mths.

Address

Pharmacy Stamp

Pharmacist's pack & quantity endorsement	No. of days treatment N.B. Ensure dose is stated		NP		*Pricing Office use only*
	2 x 28 Elleste-Duet 1mg tablets 4 x 28 Elleste-Duet 2mg tablets				
Signature of Doctor		Date			

The Pharmacy Practice Unit at King's College, London, explains the Drug Tariff logic which determines how many charges should be made and how many fees claimed on this script for HRT

Questions

1. How many professional fees does the above prescription attract?
2. How many prescription charges does the patient have to pay?

Answers

The prescription counts as four items and attracts four professional fees, but the patient has only to pay two charges.

The pharmacist can claim for four professional fees because the prescription contains four presentations of tablets, as follows:

- Elleste-Duet 1mg contains (a) 16 tablets (white) containing oestradiol 1mg, and (b) 12 tablets (green) containing oestradiol 1mg and norethisterone acetate 1mg.
- Elleste-Duet 2mg contains (c) 16 tablets (orange) containing oestradiol 2mg, and (d) 12 tablets (grey) containing oestradiol 2mg and norethisterone acetate 1mg.

As far as payment by the patient is concerned, a and c, and b and d attract one charge each, as they are classified as 'different strengths of the same drug … ordered as separate prescriptions at the same time' (Drug Tariff Part XV1, note 9.1.2.), for each of which only a single prescription charge is payable.

The total number of packs of each preparation prescribed makes no difference to the professional fee or charges, as 'the same drug or preparation … supplied in more than one container' (Drug Tariff Part XVI, note 9.1.1) attracts only a single charge.

It has, of course, long been a sore point among pharmacists that they are only paid one fee for dispensing multiple packs, or several months' supply of medication. An additional fee of 40p is payable for supplying above a threshold quantity.

This applies to many drugs in tablets or capsule form, including some hormone replacement therapy tablets, but not to any preparations containing two or more formulations in a single pack.

The pharmacist should claim for four items, including two 'no-charge', when submitting the prescription for payment.

Cut through the confusion

How can you unlock the potential of the calcium market and benefit your customers?

One in three women over the age of 50 will potentially suffer from osteoporosis – one of the most significant, yet preventable public health risks of the 21st century.

There are estimated to be three million osteoporosis sufferers in the UK and the incidence is increasing as a result of our ageing population. As a pharmacist, you are in a unique position to counsel vulnerable groups about their lifestyle in order to help them optimise their bone health.

What advice can you give?

Exercising regularly, especially weight bearing exercise such as brisk walking or jogging, is particularly beneficial. In addition, moderate exposure to sunshine helps to produce vitamin D which is needed to help absorb dietary calcium.

Diet plays a key role in maintaining healthy bones but for some of your patients achieving the recommended daily intake of calcium via their diet may not be achievable for a number of reasons.

Role of supplementation

Calcium supplements may be the best way of achieving a regular daily intake.

Those who may benefit from supplementation in particular include peri- and post-menopausal women as significant bone loss is particularly associated with the menopause. However, calcium on its own is not enough. Scientific evidence suggests that other nutrients are essential for bone health.

- Magnesium – a key bone nutrient and appears to be involved in bone formation. Involved in the metabolism of hormones which regulate calcium
- Vitamin D – needed for the active absorption of calcium from the diet
- Zinc – needed for the formation of bone cells through cell division and in the synthesis of various bone proteins
- Copper – involved in the synthesis of connective tissue present in bone
- Manganese – stimulates the production of mucopolysaccaride in bone
- Boron – synthesis of oestrogen, testosterone and vitamin D may be enhanced by boron. These hormones are involved in calcium metabolism.

The bone health market

The bone health market has shown extremely strong growth over the past 12 months at 21 per cent[1], but the pharmacy share of this is still small at less than 16 per cent.

Bone health is now gaining increasing press attention and if all those at risk around the menopause used a bone health supplement, the market would be worth £50 million, which is over six times its current value.

As a pharmacist, you can play an important role in advising at-risk groups of the importance of maintaining their bone health, and through this you can help unlock potential profits from the bone health market.

[1] *Source Information Resources MAT December 1999*

For further information or advice on nutrition please call the Whitehall Careline on 0845 111 0151 or email on *careline@md.ahp.com*

Whitehall Careline Here to help you 0845 111 0151

Caltrate Plus

A complete *calcium* supplement *plus* important nutrients essential for bone health

CALTRATE PLUS*, produced by Whitehall Laboratories, is more than just a calcium supplement. It contains calcium plus other important nutrients essential for bone health, namely vitamin D, magnesium, manganese, boron, copper and zinc.

Caltrate Plus. Helps keep bones stronger for longer.

WHITEHALL

CALTRATE Plus – Nutritional Supplement – Product Information. Each CALTRATE Plus tablet contains 5 mcg vitamin D, 600 mg calcium, 45mg magnesium, 5mg zinc, 1mg copper, 1mg manganese and 250mcg boron. Energy, protein, carbohydrate and fat content is negligible. CALTRATE Plus is suitable for adults and children over 11 years of age, or as recommended by a doctor. CALTRATE Plus is free from lactose, gluten, wheat and yeast. Available in chewable and swallow variants (swallow suitable for diabetics). **Dosage:** two tablets daily to be taken with water or as directed. CALTRATE PLUS is available in outers of 3 from all wholesalers and direct from Whitehall Laboratories. *Trade Mark

Clinical trials to go on public database

Pharmacists and other healthcare professionals will be able to access data from clinical trials under a scheme launched by the Association of the British Pharmaceutical Industry (ABPI).

The voluntary scheme will mean that authoritative data from clinical trials conducted in the UK on new medicines and sponsored by the pharmaceutical industry will be placed on a public database within three months of its registration in a major market.

Details on the database will include design and methodology, number of patients and groups of patients in the trial and its length. The aim is to provide a comprehensive reference point for researchers.

The scheme will start in January and the database will be held by CMR International. The web site is at *www.controlled-trials.com*

Floods hit pharmacies

Clear-up operations are underway as pharmacies in parts of East Sussex and Kent are trying to get back to normal in the aftermath of the recent flooding.

Boots stores in Lewes and Uckfield , two of the worst affected areas, were severely hit, with both stores completely submerged in the water.

A spokeswoman for the company said that as soon as it became apparent that the store in Uckfield would be unable to open due to 'significant flooding', Boots had been looking into the possibility of temporarily relocating to other premises.

"However, as other pharmacies in the town were operational and patients were thus able to get prescriptions dispensed we decided against it."

She added that Boots had liaised closely with the Health Authority and the Society and that it would be setting up a temporary dispensary until clear-up operations were completed.

Independent pharmacies in the two towns seem to have escaped the flooding. "We were not flooded but we were absolutely rushed off our feet all of Thursday, Friday and Saturday. We were just about the only pharmacy open in Lewes," said Stuart Bean of chemists H A Baker (Lewes). He added that the number of prescriptions being dispensed at the pharmacy had virtually tripled during the floods. Apart from the dispensary the pharmacy's photographic counter had also been extremely busy.

Tim Golding of Selby's Pharmacy in Uckfield, not far from the Boots branch, said that he had been completely unaffected, thanks to his location further up the High Street.

Clear-up operations begin in the Lewes Boots the Chemists

Boots in joint TV channel venture

Steve Morrison, chief executive of Granada, with his Boots' counterpart Steve Russell

Boots and Granada Media plc have launched a new company which will oversee the creation of an internet-portal and interactive channel, dedicated to health and wellbeing, on satellite and cable TV.

The company, whose name remains a closely guarded secret, will launch in February next year with initially 12 hours of programmes a day, produced by a dedicated team at Granada's Leeds facilities, and the web site.

A spokesman for Boots said that this was the first time any retailer had taken advantage of the new broadband technology in this way. He added that the various gateways people could use to access the information, ie television, computer or WAP phone, would ensure that everybody could use the option that was best suited to their lifestyle.

During the predominantly live programmes, which will be looking at health-related issues such as smoking cessation or weight management, the presenter will be joined by experts giving advice and answering viewers' questions. One name mentioned as a possible presenter was Steve Redgrave, the five-time Olympic champion, who suffers from diabetes himself.

The web site will provide additional information on the subjects covered in the programmes, feature chat-rooms and enable customers to order from a choice of round 10,000 health and beauty products on-line.

"Basically what the new venture will allow you to do is to sit on your sofa, watch a programme, say, on smoking cessation, then click through to the web site to find out more information and finally order a product on-line," the Boots spokesman explained.

He was, however, adamant that the web site would not become another on-line pharmacy and that no prescriptions would be dispensed through it.

Asked whether pharmacists would have any input into the programmes, a spokesman for Boots said that the new company would be keen to build on Boots' expertise.

"Pharmacy will clearly have a role to play in terms of scheduling," he said but declined to be any more specific.

Boots will own 60 per cent of the new company, while Granada will hold 40 per cent of its shares. By March, Boots expects to invest around £21.6m in the new venture, which it hopes will break even within four years.

Main sources of revenues will be the sale of products and broadcast and on-line advertising and sponsorships. Boots anticipates that new revenues will amount to around 2 per cent of current UK sales of Boots the Chemists. About 60 Boots staff have been transferred to the new company.

- Boots has acquired Clearasil, the market leader in acne prevention and treatment, from Proctor & Gamble for $340m (£235m). The total amount will be payable on completion and some patents and knowhow will be licensed. The product rights will transfer to two Boots subsidiaries, Boots Healthcare USA and Hermal in Germany.

Scarman Trust 'can do' with Lloyds

Lloydspharmacy is providing the Scarman Trust with office space above one of its stores in Handsworth, Birmingham. The charity will be paying a 'peppercorn' rent for the offices, which Lloydspharmacy has redecorated and re-carpeted.

The pharmacy chain hopes to raise awareness of the Trust's work by advertising local initiatives in the pharmacy. Staff will be trained to direct customers with queries and ideas for projects to the charity.

As of the New Year, Lloyds pharmacists will be encouraged to host discussions sessions on relevant health topics for community groups.

"It's wonderful that a major company like Lloydspharmacy is looking at developing initiatives like this," said Joan Blaney, development director for the trust in the Midlands.

Established by Lord Scarman after the civil disturbances in the early 1980s, the Scarman Trust advises community groups on accessing funds for projects such as credit unions, day centres and regeneration in deprived areas under its 'Can Do' banner.

Lloydspharmacy said the company was looking at the possibility of providing office space for the Trust in other areas in the future.

Pictured left to right are Dinife Morgan and Elizabeth Etti, workers at the Scarman Trust, with Joan Blaney, and Ray Perry, social pharmacy manager at Lloydspharmacy

Day Lewis Partnership planned

Plans for a Day Lewis Partnership were announced at the company's annual conference in Kenilworth, Warwickshire. The need to introduce an 'economy of scale' into pharmacy in order to meet the threats faced especially by independent pharmacists was cited as one of the main drivers behind the idea. Another factor had been the high cost of the re-branding.

"We realised that everything we do at Day Lewis we could do in partnership with other contractors," explained Kirit Patel, chief executive.

The Day Lewis Partnership, which is likely to get off the ground next year, is envisaged to be something more than a buying group and a franchise or acquisition.

The Partnership would work in a two-tier fashion, whereby pharmacists could decide to simply join in order to benefit from "the economy of scale" in form of a large the buying group. Alternatively contractors could opt to have the Day Lewis fascia, branding and the company's own-label products introduced.

In both cases, any discounts negotiated by Day Lewis would also be passed on to the 'partners'.

"I would expect any pharmacy entering into the partnership to put on £10,000 on the bottom line - every shop we have acquired as a chain has put that figure on," Mr Patel said.

There will be no fee for entering into the Day Lewis Partnership and Mr Patel insisted that any profits for his company would arise from sales of the Day Lewis own-brand range.

The Day Lewis chief executive added that in terms of acquisitions he was looking at adding another 100 stores to the 60 existing stores in the chain in the next few years.

Mr Patel announced that the Day Lewis group would be streamlined under one parent company, Day Lewis plc, and that the current structure and companies in the group would be phased out over the next two years. The current holding company of the 12 or so companies in the Day Lewis group, Chiporum, will cease to exist. Mr Patel also said that the company's web site, *www.daylewis.com* would be up and running within three months.

Kirit Patel, chief executive of the Day Lewis chain

Sponsors sought for Day Lewis lectures

Day Lewis is looking for sponsors to enable the company to provide a pharmacist on loan for one day a week to teach students in pharmacy practice.

The project will be piloted with the University of Brighton, but Day Lewis intends to provide a similar service with other schools of pharmacy in 'their patch', such as King's and Portsmouth.

"Boots and Lloydspharmacy are doing it, but we want to get pharmacists for the independent sector. We want to try and redress the balance."

Mr Patel anticipates the cost of the project to be around £10,000 per university, covering a full year of lectures.

The pilot is due to start sometime next year and Mr Patel promised that if the pilot proved successful the company would extend it to other universities.

Embracing IT

Small and medium-sized enterprises (SMEs) have exceeded the government's target for going on-line, two years ahead of schedule.

Figures presented by the e-commerce minister, Patricia Hewitt showed that 1.7m SMEs, or 81 per cent, were now on-line.

The Government had set the target of 1.5m SMEs by 2002. This puts the UK in the same league as the US (83 per cent) and Germany (80 per cent).

Businesses also seemed keen to embrace on-line ordering, with 27 per cent of UK businesses trading via the internet.

COMING EVENTS

OCTOBER 23

Eastbourne Branch, RPSGB, Eastbourne District General Hospital, 8pm. 'Advances in medication for the mentally ill'.

NICPPET, at the Everglades Hotel, Londonderry, 8pm. 'Immunisations and vaccinations'.

OCTOBER 24

Bury Branch, RPSGB, Macdonald Norton Grange Hotel, Rochdale, 7.30 for 8pm.

East Metropolitan Branch, RPSGB, Wanstead Library, Wanstead, 7.30 for 8pm.

NICPPET, at the Pharmaceutical Society of Northern Ireland, 8pm. 'Gastro-intestinal Cancers'.

OCTOBER 26

Bedfordshire Branch, RPSGB, at Silsoe College, 7.30 for 8pm. 'Pain relief goes to pot' by Sultan Dajani, RPSGB Council member.

Government supports EU directive for herbal remedies

The Government is putting its weight behind a proposed EU directive which would recognise and regulate traditional herbal remedies. EU governments and the European Commission agreed during a meeting of the European Pharmaceutical Committee, that the issue should be given a high priority.

The Health Minister, Lord Hunt, said: "The UK has been pressing for early action to provide clear regulatory status in European law for traditional herbal remedies, which we know are highly valued by the consumer."

He added that the MCA had taken a leading role in European discussions to argue the case for a new directive, which would in his view protect quality and safety standards while safeguarding consumer choice.

Draft proposals for the directive are expected to be made shortly by a specially formed working group.

The Shaws branch of Day Lewis has won the 'Branch of the Year Award', which carries a £200 cash prize. Accepting the award from Day Lewis's chief executive, Kirit Patel, were Shaws pharmacist, Samantha Haruna, and branch co-ordinator Caroline Bowes. Mr Patel said that he had been very impressed with how the branch dealt with being leapfrogged by another pharmacy, which is now closer to the nearby doctors' surgery

CONFERENCE BRIEFS

- Johnson & Johnson MSD are launching a madular distance learning programme far pharmacists and pharmacy assistants. The course, which is fully endarsed by the College of Pharmacy Practice will cover four topics – gastra-intestinal conditions, skin & fungal camplaints, allergies and effective communicatian skills. The modules are accompanied by separate multiple chaice questionnaires for pharmacists and pharmacy assistants. A pass rate of 70 per cent is required.
- 'Recommend medicines that have recently been switched from POM to P', advised David Mitchell, commercial directar for J&J.MSD. He said pharmacists shauld take advantage af their special pasitian ta campete with supermarkets and other retailers. He tald delegates that pharmacists aften waited far up ta 9 manths ta recommend newly switched praducts, adding that they seemed ta laose the canfidence ta recommend a praduct they had been dealing with as a POM medicine for a lang time.
- Roche has restructured its sales team ta get pharmacists more invalved in the management af diabetes and ta push the category in Day Lewis pharmacies. The team now has 18 sales staff dedicated to pharmacy with a similar number liaising with nurses. Attending pharmacists were encauraged to find a local nurse wha was prepared to hald special screening days at the pharmacy and the company promised ta support Day Lewis in the running af mare MOT days for monitaring equipment.

Classified

Appointments £27.00 P.S.C.C. + VAT minimum 3x1. General classified £18.00 P.S.C.C. + VAT minimum 3x2. Box numbers £15.00 extra. Available on request. Copy date 4pm Tuesday prior to Saturday publication. Cancellation deadline 10am Friday; one week prior to insertion date. All cancellations must be in writing. Contact Matt Gould. Chemist & Druggist (Classified), United Business Media Ltd, Sovereign Way, Tonbridge, Kent TN9 1RW. Telephone 01732 377493, Fax: 01732 377179. Internet: http://www.dotpharmacy.co.uk.
All major credit cards accepted

APPOINTMENTS

'DUBLIN'
Pharmacist for Swan Pharmacy Rathmines, Dublin 6
Excellent package for right person.
Contact Chris Byrne
Telephone: 00353 14624911
or e-mail chrisb@iol.ie

MAIDSTONE KENT
Dispenser/ Receptionist
Required for dispensing GP Surgery.
20-25 hours/week negotiable.
Start November/December.
Previous experience advantage.
CV to:
Mrs R. Langridge,
Phoenix Surgery,
33 Bell Lane, Burham,
Rochester, Kent,
ME1 35X

CROYDON AREA
Counter Assistant
For busy friendly independent Pharmacy in South Norwood. 5 day week. Good salary.
Please write with CV to:
Fishers Chemist,
1 Enmore Road,
London SE25 5NT

BUSINESS FOR SALE

DAY LEWIS **CHEMIST** *We Care* DAY LEWIS

Progressive chain of 60 shops seeks to acquire Pharmacies with turnover of in excess of £400,000 in Southeast England and East Anglia. Freehold purchases. Matter treated in the strictest confidence. For a quick decision contact:

Day Lewis Group, Bensham House,
324 Bensham Lane, Thornton Heath, Surrey CR7 7EQ
Tel: 0208 689 2255 ext. 221. Mobile 0860 484999. Fax: 0208 689 0076
Email: DayLewis@aol.com

NORTH WEST ENGLAND
Independent chain wishes to acquire Single Pharmacy or small Group. Don't give up your independence, sell it on! For a rapid decision made in the strictest confidence contact:
Gary Sawbridge
Telephone: 0151 494 2122/0780 1231615 (Mobile)
David Turner
Telephone: 0151 727 1437/0777 9791714 (Mobile)
Chemicare Health Ltd

ACCOUNTANCY SERVICES

Accountants Specialising in Pharmacists
Please take a few seconds to answer the following questions.

Yes	No	
☐	☐	Is your **top rate of tax 20%?**
☐	☐	Do you receive advice throughout the year on how to reduce your tax bills?
☐	☐	Does your accountant understand your business?
☐	☐	Is your accountant **imaginative** and proactive?
☐	☐	Does your accountant help you to **increase your profits?**
☐	☐	Are your accounts and tax returns prepared **on a timely basis?**
☐	☐	Do you have the option to pay your accountancy fees on a monthly basis to help with your cash flow?

If your answers are mainly no, please call us for more information or a free consultation.

Phone: 020 7433 1513
Hutchings Modi & Co
Accountants & Tax Consultants
www.hutchingsmodi.co.uk

LEWIS-SIMLER
CHARTERED ACCOUNTANTS
We specialise in the Pharmaceutical Industry and are fully computerised. We are therefore able to offer you the following services at very reasonable rates.

COMPUTERISED BOOK KEEPING
SALES INVOICING
PAYROLL
MANAGEMENT ACCOUNTS
CASH FLOW FORECASTS
VAT RETURNS
CREDIT CONTROL
FINANCIAL ACCOUNTS
SELF ASSESSMENT TAX RETURNS

Please contact us for Free quotation on:

Tel: 020 7482 4424 Fax: 020 7482 4623 or
E-mail: nick@eles.co.uk

C.C.T.V

CCTV SALE

Colour Quad System
4 Cameras, Quad Split
24hr VCR, 14" Screen
£1099 - 7 units available

WHOLESALE DISTRIBUTOR

Colour Multiplex System
4 Cameras, duplex, Multiplexers,
24hr VCR, 14" Screen
£1499 5 units available

Many other products available
Free Call 0800-056 0462
WEBSITE: WWW.SECURITYDIRECT.CO.UK

LOCUMS

NEED A LOCUM?

Employers Stop paying expensive agency fees.

We supply locums for only £5 per day booking fee. Your vacancy can also be sent on-line to waiting locums using the largest e-mailing lists in the UK.

All areas. Also view available dates. Many successful bookings.

Locums - simple to join o list.
Visit: www.locumline.co.uk
e-mail:
locumline@globolnet.co.uk
Phone: 07790 649346
Fox: 01923 333231

Now linked with www.thepharmacynet.com
What every Pharmacist needs

EQUIPMENT FOR SALE

PHOTO-PROCESSING FOR SALE

AKS 300. New price £30,000
Quick Sale £18,000
2 months warranty.
All accessories included.
Contact S. R. on
0113 263 8125

Relocation Sale Offers Invited

Crescent shopfitting for 2000 sq ft, 3 years old VGC includes 11 metres counters, 19 metres wall shelving, 20 metres of double sided gondola four bay pharmax drawers, 1 neon prescription sign, 1 edge illuminated prescription sign, category signage two drinks coolers, digital personal scales.

Positive Solutions EPOS with three tills and back office PC with comprehensive pharmacy database. Three years old with all wiring.

Leader lab print leader + film leader. Two years old, recently serviced. Supplied with chemicals and paper.

2 unused electric therapy couches.

Contact Salmaan
Tel: 020 8789 7629
Fax: 020 8769 5728

135 IMAGER

Under 3 years old fully maintained by Photo-Me.

Photo-Me will relocate free of charge and provide a 6 month warranty.

Best offer secures Imager.

Contact:
Bell Pharmacy
01642 314251

PRODUCTS AND SERVICES

ManMed
MANUFACTURERS OF SPECIAL PHARMACEUTICAL PRODUCTS

Bespoked Tailors of Pharmaceuticals offering

A TRADITIONAL SPECIALS SERVICE

for that "specials" patient cared for by that special professional

Where confidence in quality and price is a must and where the minimum order value is ONE.

Contact:
Karol Pazik, Director, on 01296 394142.
Mandeville Medicines, The Specialists in Specials.
For sterile, non-sterile and assembled specials, clinical trials supplies and a free help line.

LICENSED PHARMACEUTICAL ASSEMBLER

SOUTH EAST ENGLAND

Has spare capacity for P.I's. and Medicinal Products.

Telephone: 0208 850 5962

PRODUCTS AND SERVICES

NEW PRODUCT ANNOUNCEMENT

Co-pharma Heel Balm

Unique Triple Action Treatment for Dry Cracked Heels

NOTICEABLE IMPROVEMENT WITHIN 7 DAYS

Dry, cracked skin (xerosis) is a common condition involving the thickening and fissuring of the underneath and outer margins of the heels. The condition can also affect the soles of the feet, undersides of the toes, elbows and knees. In addition to being unsightly, if neglected, untreated cracks may deepen to the extent that the dermis layer of the skin is affected and may lead to painful and more serious problems, including infections.

Co-pharma Heel Balm contains high strength Urea (25%) and Allantoin, powerful Keratin softening agents, which work by chemically breaking down hard, thickened areas of skin, aiding its easy removal.

Moisturisers penetrate deeply into dry skin to increase water uptake, allowing dry skin to be replaced by soft, healthy skin.

Natural Peppermint Oil aids in leaving feet feeling fresh and cool. Will also help prevent blisters.

Co-Pharma Heel Balm is now available from all wholesalers.

PIP CODE 269-0949
AAH CODE COP 328H
Retail £5.99/100G
Tel: 01923 255580

ßeta Buying Group

Not only offers YOU

FREE MEMBERSHIP & COMPETITIVE DEALS

NOW.....

Our members are looking forward to a DISTRIBUTION OF PROFITS both to themselves and to UK registered charities!

What are you waiting for?

Tel: 01376 521246. Fax: 01376 521257.

154 Enterprise Court, Eastways Industrial Estate, Witham, Essex CM8 3YS.

WEBSITES

VETERINARY SERVICES

OBITUARIES

A1 PHARMACEUTICALS PLC

We regret to inform you of the sudden and sad death of Betty Lewis, much-loved mother of Gary Lewis MRPharmS, and mother-in-law to Carmen Lewis, co-founders of A1 Pharmaceuticals Plc.

Betty was instrumental in the early development of A1 Pharmaceuticals Plc, providing both guidance and continuing financial support.

She was extremely proud of the company's success and she will be sadly missed by those who knew her at A1. Betty devoted her life to the loving care of children, often the underprivileged or those with special needs, dutifully still working until the very end at Shelly School for Children and Young Adults with severe learning difficulties.

The funeral will be held on
Friday, 27th October 2000.

Cards, flowers or charitable donations to UNICEF or British Diabetic Association may be sent to 35 Renfrew Road, Kennington, London SE11 4NA

Business link

A free service for C&D subscribers

Free entries in 'Business Link' (maximum 30 words) are restricted to community pharmacist subscribers to *Chemist & Druggist*. No trade advertisements will be permitted. Adverts must be submitted on the coupon (right), which must be properly completed, and include an expiry date for products. Acceptance is at the discretion of the Publishers and depends on the space available. Pharmacists should only advertise medicines for sale where the product is discontinued or in short supply. Medicines must be unopened and in original packaging.

To: Business Link, CHEMIST & DRUGGIST, Sovereign House, Sovereign Way, Tonbridge, Kent TN9 1RW.

PLEASE COMPLETE IN BLOCK CAPITALS

Surname .....

First names .....

Address .....

..... Postcode .....

Personal RPSGB Registration number .....

Telephone Number .....

Proposed advertisement copy (maximum 30 words)

.....

.....

.....

.....

Back issues

The Society's 'secret' faux pas

"The Pharmaceutical Society and its Council have long been criticised for bad public relations and bad communication with the membership," said *C&D*'s **Comment** on October 11, 1975.

The faux pas under attack on this occasion was the decision to keep 'secret' the ruling that community pharmacists should record sales of some medicines considered liable to abuse. The president wrote personally to the membership about the decision but this came unstuck after problems with the postal service.

Pharmacists had no guidance on the subject, but instead heard on radio or television, or from customers about what they were supposed to be doing. *C&D*'s comment called it "stupid" to keep secret the fact that the patients were to be asked to sign for well-known medicines.

Another 75 years previously, in October 1900, Xrayser spotted a pointer to the future make-up of the pharmacy workforce. Examining the list of successful examination candidates, he found that "out of the 521 names published, no fewer than 40 were Mays, Margarets, Elsies, Rosies and the like. There may have been more misses concealed among those whose initials are only given".

He went on to observe that "a good dozen of these embryo pharmaciennes are Scotch - a circumstance which suggests that the apprentice difficulty there may settle itself in peace and pleasantness after all".

That same month saw an interesting selection of 'Brevities', including:

- A bullock in prime condition (left) entered the establishment of the Co-operative Drug Company in Plymouth on October 10, but was removed without causing any damage. This is the second bullock which has visited this drug store.
- John Wright of Thirsk, two samples of whose ginger beer were certified by Somerset House to contain 3.4 per cent and 4.8 per cent of proof spirit respectively, has been fined 1s without costs.

Showers in the North-West

Not all pharmacies are refitted with a shower but then not all pharmacists are champion triathletes!

Nicola Lancashire, the branch manager of a United Norwest Co-op pharmacy, is the North West's Triathlon champion for her age group. So, when the branch was recently refurbished, the company agreed to fit a shower for her.

A triathlon involves swimming one mile, cycling for 26 miles and running for ten kilometres. To keep up with her training Nicola often cycles the nine miles to work or runs home.

Roy Barraclough is pictured with Nicola Lancashire (right) and other members of staff

The branch, in Horsedge Street, Oldham, was re-opened by Coronation Street's former licensee 'Alec Gilroy'. Otherwise known as Roy Barraclough, the actor has been a customer of the branch for 24 years.

After cutting the ribbon he mingled with customers and said: "I'm still coming here so they must be doing something right!"

La Dolce Vita

Tony Blair would surely approve. Cool Britannia is so cool that even its pharmacists organise fashion shows. Jitendra Sheth, a Luton-based locum, entered the world of catwalks and temperamental models as a favour for his friend, Darshna Shah. His brief was to organise a fashion show in two months. Sounds good, he thought, until he discovered how much hard graft is involved behind all that glitter. Getting sponsors, buyers, models, and bums on seats on the big day apparently needs someone who combines the diplomatic skills of Kofi Anan with Maggie Thatcher's work rate. "It was a very stressful experience, with DJs and models cancelling before and on the day of the show. And at one point I thought the show would not take place at all," said Jitendra.

Jitendra Sheth, at home in the pharmacy; models strut their stuff on the catwalk

But, in time-honoured tradition, it all came good on the night. The event, held at the American Intercontinental University in London, raised £1,000.

Jitendra enjoyed the experience so much he wants to make a living out of it. "I still enjoy pharmacy, but being a locum doesn't bring enough stimulation, so I need this challenge," he said.

Water, water everywhere, nor any drop to drink...

... so we went down to the pub, instead.

Well, this was after first making it onto the national news last week, when the stream outside our office decided it couldn't contain all the flood waters of the Medway and burst its banks.

Eagle-eyed viewers may have seen the neighbouring supermarket car park/paddy fields on the telly as it featured in the coverage of the Kent and Sussex floods. Our Tonbridge office was marooned on Friday - one of the car parks was under 2ft of water - and the local shoe shops did an admirable trade selling sensible gumboots to those members of staff willing to wade into work.

Fortunately for us, there was no damage to the building, and not too much disruption in the town, unlike Lamberhurst or Uckfield and Lewes on the other side of the Weald (see also **Business News**). But as Tonbridge ground to a standstill with traffic unable to move along the High Street, and a rising water level causing the computer mainframe to be switched off, the not-well staffed office emptied.

Thank goodness, then, that the local hostelry is set well back from the river and was able to provide some comfort from the raging torrents.

Charlie Dimmock of BBC's Ground Force may find inspiration from the *C&D* sunken rose garden

Simply the best for pharmacy assistants

Over the Counter magazine

Next issue out on November 25. Special features include:

- **Colds and flu – diagnosis and treatment**
- **Coping with constipation**
- **Focus on calcium**
- **The latest news on hair colorants**

PLUS...
Photography – hints and tips for top snaps this Christmas